DISABILITY RETIREMENT KIT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53726 (Rev. 01-06)

NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920
www.nd.gov/ndpers

This publication contains information, forms, and instructions necessary for a terminating employee to apply for disability retirement benefits and insurance under the Defined Benefit Plan. This publication is to be completed by BOTH the employer and employee.

This publication is intended to provide general information and may not be considered to be a legal interpretation of law. Statements contained in this publication do not supersede the North Dakota Century Code or Administrative Code or restrict the authority granted to the Retirement Board.

The information in this publication is subject to changes made by the North Dakota legislature, by the Board of the North Dakota Public Employees Retirement System (NDPERS), and its agents.

NAVIGATING THE DISABILITY RETIREMENT KIT

COMPLETE FORMS IN BLUE OR BLACK INK

EMPLOYER Responsibility

The Notice of Status or Employment Change SFN 53611 MUST be completed by your employer and MUST accompany your FINISHED retirement kit.

Your disability retirement kit will not be PROCESSED without this form.

RETIREE Responsibility

Before completing any forms, read all instructions, as well as the terms, and conditions on the back of each form.

1. GROUP RETIREMENT PLAN

The disability benefits described in this section ONLY pertain to members of NDPERS Defined Benefit Plan.

Read the "Group Retirement Plan-Disability Benefits" sheet carefully before proceeding.

- √ If you have not already done so, complete the NDPERS Request for Benefit Information SFN 53603 to request a disability benefit estimate. You may also access your retirement account through the NDPERS On-line Services at www.nd.gov/ndpers.
- √ You MUST complete the Application for Disability Retirement SFN 18000 and send it to NDPERS within 12 months of termination of eligible employment.
- √ NDPERS must receive an application for disability retirement benefits and appropriate legal documentation at least 31 days before the distribution of the first disability retirement check.

If documents are filed too late, the payment will be DELAYED.

- √ Your immediate supervisor or another individual possessing comprehensive knowledge regarding the occupational demands of your job MUST complete the Disability Retirement Occupation Demands SFN 54398.
- √ Your attending physician MUST complete the Disability Retirement Attending Physician's Statement of Disability SFN 54399. If you have more than one attending physician, you can photocopy this form and distribute accordingly.

√ It is NDPERS policy that all annuity payments are required to be direct deposited. Read the Direct Deposit by Automated Clearing House (ACH) information sheet. Complete the Authorization for Direct Deposit for Annuity Payment SFN 18379.

√ Federal tax MUST be deducted if a completed W-4P is not returned (married/3 allowances). North Dakota state income tax is 21% of your Federal withholding. Complete the W-4P (Substitute) Tax Withholding Certificate SFN 51506. NDPERS uses monthly payroll period from the IRS Income Tax Withholding Tables.

2. GROUP HEALTH INSURANCE

Read the "Dakota Plan, Dakota Retiree Plan & Dakota Health Plan Features" sheets carefully before proceeding.

Choose one of the following options:

A. Continue your CURRENT level of coverage through NDPERS, complete the Retiree Continuation of Group Health Insurance Coverage(COBRA) SFN 53799.

B. Waive continuation of your CURRENT level of coverage through NDPERS, complete the Retiree Continuation of Group Health Insurance Coverage (COBRA) SFN 53799.

C. Continue NDPERS coverage but at a REDUCED level, complete the Retiree Continuation of Group Health Insurance Coverage COBRA) SFN 53799 AND the Retiree Group Health Insurance Application SFN 16277.

D. Apply for New Coverage through NDPERS, complete the Retiree Group Health Insurance Application SFN 16277. If you and/or your spouse/dependents are Medicare eligible, each of you must complete a Medicare Blue Rx application. If required, the application will be mailed to you.

E. Waive New Coverage through NDPERS, complete the Retiree Group Health Insurance Application SFN 16277.

F. Continue coverage through NDPERS, BUT you and/or your spouse/dependent(s) are Medicare eligible, complete the Retiree Group Health Insurance Application SFN 16277 and Medicare Blue Rx application. If Medicare eligible, each of you must complete a Medicare Blue Rx application. If required, the application will be mailed to you.

3. GROUP LIFE INSURANCE

Read the Life Insurance Continuation sheet carefully before proceeding.

Choose one of the following options:

A. Continue CURRENT level of coverage through NDPERS, complete the Retiree Life Insurance Application SFN 53622.

B. Waive CURRENT level of coverage through NDPERS, complete the Retiree Life Insurance Application SFN 53622. Complete the Application for Conversion of Group Life Insurance if you wish to obtain cost information to convert your supplemental & dependent term life insurance to an individual policy with the life insurance carrier.

C. Continue coverage through NDPERS BUT at a REDUCED level, complete the Retiree Life Insurance Application SFN 53622.

D. Apply for waiver of premium, complete the Prudential Group Life Claim for Disability Benefits GL.2003.015 and the Prudential Group Life Benefit Attending Physician's Statement GL.2002.119.

If continuing life insurance, also update your designation of beneficiary on the Retiree Life Insurance Application SFN 53622.

For premium information see the Life Insurance Rate Chart.

4. GROUP DENTAL INSURANCE

Read the "Retiree Dental Coverage" sheet carefully before proceeding.

Choose one of the following options:

A. Continue CURRENT level of coverage through NDPERS, complete the Retiree Continuation of Group Dental Insurance Coverage (COBRA) SFN 53800.

B. Waive continuation of your current coverage through NDPERS, complete the Retiree Continuation of Group Dental Insurance Coverage (COBRA) SFN 53800.

C. Continue coverage through NDPERS BUT at a REDUCED level, complete the Retiree Continuation of Group Dental Insurance Coverage (COBRA) SFN 53800 AND the Retiree Dental Insurance Enrollment/Change SFN 53504.

D. Apply for New Coverage through NDPERS, complete the Retiree Dental Insurance Enrollment/Change SFN 53504.

E. Waive New Coverage through NDPERS, complete the Retiree Dental Insurance Enrollment/Change SFN 53504.

5. GROUP VISION INSURANCE

Read the "Retiree Vision Coverage" sheet carefully before proceeding

Choose one of the following options:

A. Continue CURRENT level of coverage through NDPERS, complete the Retiree Continuation of Group Vision Insurance Coverage (COBRA) SFN 53801.

B. Waive continuation of your current coverage through NDPERS, complete the Retiree Continuation of Group Vision Insurance Coverage (COBRA) SFN 53801.

C. Continue coverage through NDPERS BUT at a REDUCED level, complete the Retiree Continuation of Group Vision Insurance Coverage (COBRA) SFN 53801 AND the Retiree Vision Insurance Enrollment/Change SFN 53505.

D. Apply for New Coverage through NDPERS, complete the Retiree Vision Insurance Enrollment/Change SFN 53505.

E. Waive New Coverage through NDPERS, complete the Retiree Vision Insurance Enrollment/Change SFN 53505.

6. COBRA NOTIFICATION LETTER

Federal COBRA Law: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that employers provide employees and their dependents who lose their eligibility to participate in a Group Health, Group Dental and Group Vision insurance plan an opportunity to continue comparable coverage at their own expense.

7. GROUP INSURANCE PAYMENT METHODS

If your group insurance(s) is/are not deducted from an annuity payment, it is NDPERS policy that your premium(s) be deducted from a Bank Account. Complete the Automatic Premium Deduction SFN 50134. It is the policy of NDPERS that a member's net annuity payment can not be less than $25.00.

8. GROUP LONG TERM CARE PLAN

Read the "Long-Term Care Coverage" sheet carefully before proceeding

A. Continue coverage through UNUM/NDPERS, complete the UNUM Election for Portable Coverage. Complete within in 31 days from last day of employment.

B. Apply for New Coverage through UNUM/NDPERS, read the "Retiree Long Term Care Coverage sheet" to obtain information.

9. FLEXIBLE BENEFITS

Read the "FlexComp Notice of Termination" sheet carefully before proceeding.

Choose one of the following options:

A. Continue NDPERS Medical Spending Account participation, complete the Continuation of Coverage in a Medical Spending Account (COBRA) SFN 53512.

B. Waive NDPERS Medical Spending Account participation, complete the Continuation of Coverage in a Medical Spending Account (COBRA) SFN 53512.

COBRA Notification Letter
Federal COBRA Law: The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) allows you the opportunity to extend your participation in the NDPERS Medical Spending Account to the end of the current plan year.

10. DEFERRED COMPENSATION PLAN

Read the "The Deferred Compensation Plan Termination Notice" sheet carefully before proceeding.

11. EMPLOYEE ASSISTANCES PROGRAM

Cancels automatically.

CHECKLIST

	FORM NAME	SFN #
☐	NOTICE OF STATUS OR EMPLOYMENT CHANGE	53611
☐	NDPERS REQUEST FOR DISABILITY BENEFIT INFORMATION	53603
☐	APPLICATION FOR DISABILITY RETIREMENT BENEFITS	18000
☐	DISABILITY RETIREMENT OCCUPATIONAL DEMANDS	54398
☐	DISABILITY RETIREMENT ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY	54399
☐	LEGIBLE PHOTOCOPIES OF BIRTH CERTIFICATE, SPOUSE'S BIRTH CERTIFICATE & MARRIAGE CERTIFICATE	
☐	DESIGNATION OF BENEFICIARY FOR THE GROUP RETIREMENT PLAN	2560
☐	AUTHORIZATION FOR DIRECT DEPOSIT FOR ANNUITY PAYMENT	18379
☐	FORM W-4P (SUBSTITUTE) TAX WITHHOLDING CERTIFICATE	51506
☐	CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)	53799
☐	RETIREE GROUP HEALTH INSURANCE APPLICATION	16277
☐	RETIREE LIFE INSURANCE APPLICATION	53622
☐	PRUDENTIAL GROUP LIFE CLAIM FOR TOTAL DISABILITY BENEFITS	GL 2003.015
☐	PRUDENTIAL GROUP LIFE BENEFITS ATTENDING PHYSICIAN'S STATEMENT	GL 2002.119
☐	RETIREE CONTINUATION OF GROUP DENTAL COVERAGE (COBRA)	53800
☐	RETIREE DENTAL INSURANCE ENROLLMENT/CHANGE	53504
☐	RETIREE CONTINUATION OF GROUP VISION INSURANCE COVERAGE (COBRA)	53801
☐	RETIREE VISION INSURANCE ENROLLMENT/CHANGE	53505
☐	AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION	50134
☐	UNUM ELECTION FOR PORTABLE COVERAGE	Form
☐	CONTINUATION OF COVERAGE IN MEDICAL SPENDING ACCOUNT (COBRA)	53512

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DISABILITY RETIREMENT BENEFITS

Effective July 1, 2005 – June 30, 2007

To be eligible for benefits listed on this sheet, you must terminate employment. The Administrative Code Chapter 71-02-01-01(24) states: "Termination of employment" means a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence does not constitute termination of employment.

NDPERS ON-LINE BENEFIT SERVICES

You have the ability to access your individual retirement account balance, annual statements, and the tools needed to compute retirement and disability benefits. You also have access to plan information on all NDPERS benefits, Perspectives Newsletters, News Flashes, Forms and Publications, and Contact Information. NDPERS website address is www.nd.gov/ndpers.

DISABILITY RETIREMENT BENEFIT – WHAT IS IT?

The disability retirement benefit is funded by your employer's contributions. The Plan provides a monthly benefit payment to eligible participants who are unable to engage in substantial gainful employment for an extended period of time.

WHO IS COVERED UNDER THE DISABILITY BENEFIT PLAN?

All participating members of the NDPERS Defined Benefit Plan who have accumulated six (6) months of eligible service are covered under the disability retirement plan.

ELIGIBILITY REQUIREMENTS

To be eligible for NDPERS disability retirement benefits the following must apply:

- Your disability must have occurred during a period of eligible employment.
- You must be unable to engage in any substantial gainful activity due to a medically determinable physical or mental impairment expected to result in death or which will or has lasted for a continuous period of not less than twelve months.
- You must submit a "Disability Retirement Kit SFN 53726" to the NDPERS office within 12 (twelve) months of termination of employment due to disability.
- You must be determined to be disabled by the NDPERS' medical advisor, who is responsible for making disability eligibility determinations for the Board. The processing is an average of 45 days. In lieu of a review by the NDPERS' medical advisor, a member who qualifies for Social Security Disability benefits and submits a "Disability Retirement Kit SFN 53726" with a copy of the Social Security Notice of Award, will be deemed eligible for NDPERS disability benefits without requiring a determination from the medical advisor. The Social Security Notice of Award must provide proof that the member's disability was determined during his/her period of eligible employment. Eligibility for disability benefits will be subject to ongoing recertification requirements as specified by the NDPERS' medical advisor.

HOW TO APPLY FOR DISABILITY BENEFITS

You may submit a "NDPERS Disability Retirement Kit SFN 53726" up to four (4) months prior to your date of termination. However, **you must submit an application to NDPERS within 12 months of your termination date**. You may obtain a "NDPERS Disability Retirement Kit SFN 53726" from your payroll office, the NDPERS office, or the NDPERS Website.

If you are at least 55 years of age and have a minimum of thirty-six (36) months of service credit, you may also apply for early retirement benefits. This will allow NDPERS to pay you under Early Retirement provisions while your disability application is being processed. To apply for early retirement benefits, you must complete a **"**Retirement Kit SFN 53723**".**

In the event a member who is applying for disability benefits passes away prior to receiving benefits, the provisions covering "death benefits" will apply.

COORDINATION WITH OTHER DISABILITY PLANS

Your NDPERS disability benefit payment will not be reduced by any other benefits you may be receiving as a result of your disability.

DISABILITY BENEFIT PAYMENTS

If the medical advisor determines that you are totally and permanently disabled according to the Plan, your benefit is payable retroactive to the first of the month following your date of termination. The benefit is payable as long as you are disabled.

Your disability retirement benefit is computed as 25% of your final average salary. The minimum basic disability benefit is $100.00 per month. Final average salary is the average of your highest 36 of the last 120 months you worked. You may obtain an estimate of your disability benefits by completing a "Request for Benefit Information SFN 53603" or obtain it through NDPERS Online Services at www.nd.gov/ndpers. There are several different payment options to choose from under disability retirement. These payment options differ in how they pay your beneficiary in the event of your death, and in the actuarial reduction necessary to provide these benefits to your beneficiary.

SINGLE LIFE DISABILITY RETIREMENT BENEFIT: This amount is payable to you for as long as you are disabled. Under this option there is no monthly income provision for your beneficiary. If you should die while receiving disability benefits, your beneficiary will get a lump sum payment of the amount in your member account.

50% JOINT AND SURVIVOR: This amount is payable to you for as long as you are disabled, but is actuarially reduced based upon your age and the age of your spouse. In the event of your death, your spouse will receive 50% of your monthly disability benefit amount for the rest of his/her life. If your spouse dies first, your benefit will be adjusted back to the single life disability amount upon written notification and a photocopy of your spouse's "Certificate of Death".

100% JOINT AND SURVIVOR: This amount is payable to you for as long as you are disabled, but is actuarially reduced based upon your age and the age of your spouse. In the event of your death, your spouse will receive 100% - - the same amount as you

were receiving prior to death - - of your monthly disability benefit amount for the rest of his/her life. If your spouse dies first, your benefit will be adjusted back to the single life disability amount upon written notification and a photocopy of your spouse's "Certificate of Death".

TWENTY (20) YEAR TERM CERTAIN: This amount is reduced based upon actuarial factors, and is payable to you for as long as you are disabled. If you should die within the first twenty years of your disability retirement, your beneficiary will receive a monthly payment for the remainder of the term, and a lump sum payment of the balance of the account, if any, is made at the end of the term. If payment to you has been longer than the guaranteed term, your beneficiary will only receive the account balance, if a balance remains.

TEN (10) YEAR TERM CERTAIN: This amount is reduced based upon actuarial factors, and is payable to you for as long as you are disabled. If you should die within the first ten years of your disability retirement, your beneficiary will receive a monthly payment for the remainder of the term and a lump sum payment of the balance, if any, of the account is made at the end of the term. If payment to you has been longer then the term, your beneficiary will only receive the account balance, if a balance remains.

DENIAL OF BENEFITS – REVIEW PROCEDURE

If you receive written notice that your application for disability retirement has been denied, you may request a review of the decision. A written request for review must be received in the NDPERS office within 60 days of receiving a denial notice. You will be notified of the time and date of the appeal hearing and may attend and/or be represented by legal counsel. The appeal discussion is confidential and closed to the general public.

If the Board's decision is to uphold the recommendation of the medical advisor, the applicant may file a request for a formal hearing to be conducted before an administrative law judge.

RECERTIFICATION OF DISABILITY STATUS

Your eligibility to continue to receive disability benefits must be recertified 18 months after the date your first check is issued and thereafter as specified by the medical consultant.

Four (4) months prior to the 18 month payment anniversary date, you will receive an "Application for Recertification of Disability Benefits" and a "Recertification of Disability-Attending Physician's Statement". These two forms are to be completed and returned to NDPERS.

Also, as a part of the recertification process, you will be required to complete a "Statement of Annual Earnings for Disability Annuitants SFN 53157" to document any employment. (See Return to Work Provisions).

If it is determined that you were not eligible for benefits during any time period when benefits were provided, the executive director may do all things necessary to recover the erroneously paid benefits.

TAXES AND YOUR BENEFIT PAYMENT

The NDPERS disability benefit is provided by your employer's contributions to the retirement system and is therefore 100% taxable before age 65. At age 65, your benefit is considered a retirement benefit for income tax purposes. A portion of your monthly benefit may be non-taxable, based upon your contributions to your member account balance. An exclusion ratio will be computed to determine your non-taxable portion, if any.

According to IRS Regulation Section 1.72-15(c)(2), your member account balance will not be reduced before age 65. At age 65, your member account balance is reduced by the monthly benefit payments you receive.

You have the option of having federal and North Dakota state income taxes withheld from your monthly benefit payment. At the time of your retirement, NDPERS will have you complete a federal W-4P withholding form. You may elect not to have income tax withheld from your pension payment by using the same form. You may change your tax withholding election at any time, and as often as you wish.

If you do not have federal income tax withheld from your benefit payment, you cannot have ND state income tax withheld. You can choose a specific amount for federal withholding, but the ND state tax amount to be deducted is not flexible and will be 21% of federal tax being withheld, if elected.

Whether you should have taxes withheld depends upon your financial situation. In January of each year, NDPERS will send you a 1099-R form showing the total annuity paid, the taxable and non-taxable amount and the total deductions for federal and North Dakota state income tax. The 1099-R form is to be used in filing your annual income tax return.

Questions about the amount of taxes to withhold or the need for tax deduction should be directed to a professional tax consultant.

DIRECT DEPOSIT

After receiving your first check, you may have your monthly payment sent directly to your checking or savings account through Direct Deposit. You and your bank must complete a "Authorization for Direct Deposit SFN 18379" 30 days before the date of deposit. To change banks, simply complete a new direct deposit form with the new financial institution. NDPERS will not accept alternate Direct Deposit forms. Deposits are electronically sent for deposit the first working day of each month. You will receive a QUARTERLY statement of the deposits made.

RETURN TO WORK PROVISIONS

If you return to work in a permanent full-time position and are eligible to participate in NDPERS, your monthly benefits must be suspended. If you are not able to continue employment for a consecutive period of time resulting in nine (9) months of service credit as a result of the disability and continue to meet eligibility requirements under the plan, you may resume disability status with NDPERS.

If you return to substantial gainful activity in employment not covered under NDPERS, the disability benefit may continue for up to nine (9) consecutive months. If you are not

able to continue employment for at least nine (9) months as a result of the disability and continue to meet eligibility requirements under the plan, you may continue disability status with NDPERS.

You must notify NDPERS in writing if you return to work. Verification of employment will also be monitored through the recertification process.

RETIREE INSURANCE COVERAGE

The NDPERS Health, Dental, Vision, and Long-Term Care insurance plans are available to you even if your employer did not participate in these NDPERS Plans prior to your disability.

You may enroll in the above insurance if you do so within 31 days of disability retirement or during the eligible qualifying events. Please refer to the NDPERS website for each plan's qualifying events, premium information, and plan design.

RETIREE HEALTH CREDIT

The Retiree Health Insurance Credit Program offers you a credit which reduces your health insurance premiums upon retirement. This credit can only be used if you choose to participate in the NDPERS Dakota Plan or Dakota Retiree Plan and are drawing a monthly NDPERS or NDHPRS benefit payment.

You receive $4.50 for every year of retirement service credit, subject to REDUCTION FOR EARLY RETIREMENT. Your retiree health insurance credit will not be reduced if you are age 65, meet the Rule of 85 or are receiving NDPERS Disability retirement benefits. Your credit will be applied automatically when you retire and participate in the Dakota Plan or Dakota Retiree Plan. Under the **Standard Option**, upon your death, your retiree health insurance credit will be transferred to your surviving spouse if your surviving spouse receives a monthly payment from NDPERS and participates in the Dakota Plan. He or she can use the health insurance credit for as long as the benefit payments continue.

Under the **Alternate Health Credit Option**, if you are married and choose a Single Life, Twenty or Ten Year Term Certain, or Level Social Security retirement option, you have the opportunity to elect an alternate form of retiree health insurance credit. You may choose an actuarially reduced 50% or 100% Joint & Survivor retiree health credit option that applies only to the health credit portion of your retirement benefits.

The alternate option is actuarially reduced based upon your age and the age of your spouse. If you elect an alternate health credit option, upon your death, your surviving spouse will receive a health insurance credit amount, if covered by the Dakota Plan or Dakota Retiree Plan, for the spouse's lifetime.

DEFINITIONS
(Reference – N.D.A.C. Chapter 71-02-01-01)

Leave of absence means the period of time up to one year for which an individual may be absent from covered employment without being terminated. At the executive director's discretion, the leave of absence may be extended not to exceed two years, or indefinitely if the leave of absence is due to interruption of employment.

Medical consultant means a person or committee appointed by the board of the North Dakota Public Employees Retirement System to evaluate medical information submitted in relation to disability applications, recertifications, and rehabilitation programs or other such duties as assigned by the board.

Permanent and total disability for members of the main retirement system and the national guard/law enforcement retirement plan means the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve months. For members of the judge's retirement plan, "permanent and total disability" is determined pursuant to subdivision e of subsection 3 of section 54-52-17 of the North Dakota Century Code.

Substantial gainful activity is to be based upon the totality of the circumstances including consideration of an individual's training, education, and experience; an individual's potential for earning at least seventy percent of the individual's predisability earnings; and other items deemed significant on a case-by-case basis. Eligibility is based on an individual's employability and not actual employment status.

Termination of employment- means a severance of employment by not being on the payroll of a covered employer for a minimum of one month. Approved leave of absence does not constitute termination of employment.

NDPERS REQUEST FOR BENEFIT INFORMATION
NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53603 (Rev. 03/04)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Section 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • PO Box 1657 • Bismarck • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

COMPLETE AND SEND TO NDPERS TO RECEIVE A BENEFIT ESTIMATE

PART A MEMBER INFORMATION	
Name:	
Social Security Number:	
Address:	
City:	
State:	Zip Code + 4:
Daytime Phone:	
PART B RETIREMENT PROJECTION (PLEASE LIMIT TO 2 PROJECTIONS)	
☐ Age 55 ☐ Age 62 ☐ Age 65 ☐ Earliest Rule of 85	
☐ Other –Specify Date: _____ ☐ Disability – Specify Date: _____	
PART C SICK LEAVE CONVERSION (LEAVE BLANK IF CONVERSION IS NOT DESIRED)	
Number of hours of accumulated sick leave _____	

Direct Deposit by Automated Clearing House

(ACH)

ACH Direct Deposit service for the convenience of PERS benefit recipients

It is NDPERS Board's policy that all annuity payments are required to be direct deposited. This method of transferring funds is safe, secure and used nationwide. You do not have to change your current bank relationship to take advantage of this service. It is available through all banks, credit unions, savings and loans facilities and most other financial institutions.

ADVANTAGES TO DIRECT DEPOSIT:

- The money will be there on time each month.
- Your worries about mail delays or stolen checks are over.
- You'll avoid waiting in long bank lines to cash or deposit checks.
- Your money will be deposited quicker – the first business day of each month, which allows you to access money more quickly than before.

To begin Direct Deposit, simply complete an Authorization for Direct Deposit for Annuity Payments SFN 18379

You must complete and sign the "Annuitant/Payee" part of the form.

Your bank must complete the "Financial Institution" part of the form.

Return the form to the PERS office by the 14th of any month. Your Direct Deposit of PERS benefit payments will begin the first of the following month, unless an alternate effective date is requested. **(Your FIRST benefit payment must be mailed to your home address).**

To change financial institutions or change ANY account information, just complete an Authorization for Direct Deposit for Annuity Payments SFN 18379.

Every three months NDPERS will send you a "quarterly statement of deductions". This statement gives you a record of all monthly deductions made from your benefit payment before deposit. It also provides convenient year-to-date totals of all deductions and benefit payments for your records.

Direct Deposit is safe, convenient and easy. Benefit payments are deposited electronically into YOUR bank account.

There are no service fees charged by PERS for this service. It's free! However, you may have to check with your bank for any possible fees.

SINGLE Persons—**MONTHLY** Payroll Period

(For Wages Paid in 2006)

If the wages are–		And the number of withholding allowances claimed is—										
At least	But less than	0	1	2	3	4	5	6	7	8	9	10
		The amount of income tax to be withheld is—										
$0	**$220**	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
220	**230**	0	0	0	0	0	0	0	0	0	0	0
230	**240**	1	0	0	0	0	0	0	0	0	0	0
240	**250**	2	0	0	0	0	0	0	0	0	0	0
250	**260**	3	0	0	0	0	0	0	0	0	0	0
260	**270**	4	0	0	0	0	0	0	0	0	0	0
270	**280**	5	0	0	0	0	0	0	0	0	0	0
280	**290**	6	0	0	0	0	0	0	0	0	0	0
290	**300**	7	0	0	0	0	0	0	0	0	0	0
300	**320**	9	0	0	0	0	0	0	0	0	0	0
320	**340**	11	0	0	0	0	0	0	0	0	0	0
340	**360**	13	0	0	0	0	0	0	0	0	0	0
360	**380**	15	0	0	0	0	0	0	0	0	0	0
380	**400**	17	0	0	0	0	0	0	0	0	0	0
400	**420**	19	0	0	0	0	0	0	0	0	0	0
420	**440**	21	0	0	0	0	0	0	0	0	0	0
440	**460**	23	0	0	0	0	0	0	0	0	0	0
460	**480**	25	0	0	0	0	0	0	0	0	0	0
480	**500**	27	0	0	0	0	0	0	0	0	0	0
500	**520**	29	1	0	0	0	0	0	0	0	0	0
520	**540**	31	3	0	0	0	0	0	0	0	0	0
540	**560**	33	5	0	0	0	0	0	0	0	0	0
560	**580**	35	7	0	0	0	0	0	0	0	0	0
580	**600**	37	9	0	0	0	0	0	0	0	0	0
600	**640**	40	12	0	0	0	0	0	0	0	0	0
640	**680**	44	16	0	0	0	0	0	0	0	0	0
680	**720**	48	20	0	0	0	0	0	0	0	0	0
720	**760**	52	24	0	0	0	0	0	0	0	0	0
760	**800**	56	28	1	0	0	0	0	0	0	0	0
800	**840**	60	32	5	0	0	0	0	0	0	0	0
840	**880**	65	36	9	0	0	0	0	0	0	0	0
880	**920**	71	40	13	0	0	0	0	0	0	0	0
920	**960**	77	44	17	0	0	0	0	0	0	0	0
960	**1,000**	83	48	21	0	0	0	0	0	0	0	0
1,000	**1,040**	89	52	25	0	0	0	0	0	0	0	0
1,040	**1,080**	95	56	29	1	0	0	0	0	0	0	0
1,080	**1,120**	101	60	33	5	0	0	0	0	0	0	0
1,120	**1,160**	107	66	37	9	0	0	0	0	0	0	0
1,160	**1,200**	113	72	41	13	0	0	0	0	0	0	0
1,200	**1,240**	119	78	45	17	0	0	0	0	0	0	0
1,240	**1,280**	125	84	49	21	0	0	0	0	0	0	0
1,280	**1,320**	131	90	53	25	0	0	0	0	0	0	0
1,320	**1,360**	137	96	57	29	2	0	0	0	0	0	0
1,360	**1,400**	143	102	61	33	6	0	0	0	0	0	0
1,400	**1,440**	149	108	67	37	10	0	0	0	0	0	0
1,440	**1,480**	155	114	73	41	14	0	0	0	0	0	0
1,480	**1,520**	161	120	79	45	18	0	0	0	0	0	0
1,520	**1,560**	167	126	85	49	22	0	0	0	0	0	0
1,560	**1,600**	173	132	91	53	26	0	0	0	0	0	0
1,600	**1,640**	179	138	97	57	30	2	0	0	0	0	0
1,640	**1,680**	185	144	103	62	34	6	0	0	0	0	0
1,680	**1,720**	191	150	109	68	38	10	0	0	0	0	0
1,720	**1,760**	197	156	115	74	42	14	0	0	0	0	0
1,760	**1,800**	203	162	121	80	46	18	0	0	0	0	0
1,800	**1,840**	209	168	127	86	50	22	0	0	0	0	0
1,840	**1,880**	215	174	133	92	54	26	0	0	0	0	0
1,880	**1,920**	221	180	139	98	58	30	3	0	0	0	0
1,920	**1,960**	227	186	145	104	62	34	7	0	0	0	0
1,960	**2,000**	233	192	151	110	68	38	11	0	0	0	0
2,000	**2,040**	239	198	157	116	74	42	15	0	0	0	0
2,040	**2,080**	245	204	163	122	80	46	19	0	0	0	0
2,080	**2,120**	251	210	169	128	86	50	23	0	0	0	0
2,120	**2,160**	257	216	175	134	92	54	27	0	0	0	0
2,160	**2,200**	263	222	181	140	98	58	31	3	0	0	0
2,200	**2,240**	269	228	187	146	104	63	35	7	0	0	0
2,240	**2,280**	275	234	193	152	110	69	39	11	0	0	0
2,280	**2,320**	281	240	199	158	116	75	43	15	0	0	0
2,320	**2,360**	287	246	205	164	122	81	47	19	0	0	0
2,360	**2,400**	293	252	211	170	128	87	51	23	0	0	0
2,400	**2,440**	299	258	217	176	134	93	55	27	0	0	0

SINGLE Persons—**MONTHLY** Payroll Period

(For Wages Paid in 2006)

If the wages are–		And the number of withholding allowances claimed is—										
At least	But less than	0	1	2	3	4	5	6	7	8	9	10
		The amount of income tax to be withheld is—										
$2,440	**$2,480**	$305	$264	$223	$182	$140	$99	$59	$31	$4	$0	$0
2,480	**2,520**	311	270	229	188	146	105	64	35	8	0	0
2,520	**2,560**	317	276	235	194	152	111	70	39	12	0	0
2,560	**2,600**	323	282	241	200	158	117	76	43	16	0	0
2,600	**2,640**	329	288	247	206	164	123	82	47	20	0	0
2,640	**2,680**	335	294	253	212	170	129	88	51	24	0	0
2,680	**2,720**	343	300	259	218	176	135	94	55	28	0	0
2,720	**2,760**	353	306	265	224	182	141	100	59	32	4	0
2,760	**2,800**	363	312	271	230	188	147	106	65	36	8	0
2,800	**2,840**	373	318	277	236	194	153	112	71	40	12	0
2,840	**2,880**	383	324	283	242	200	159	118	77	44	16	0
2,880	**2,920**	393	330	289	248	206	165	124	83	48	20	0
2,920	**2,960**	403	336	295	254	212	171	130	89	52	24	0
2,960	**3,000**	413	344	301	260	218	177	136	95	56	28	1
3,000	**3,040**	423	354	307	266	224	183	142	101	60	32	5
3,040	**3,080**	433	364	313	272	230	189	148	107	65	36	9
3,080	**3,120**	443	374	319	278	236	195	154	113	71	40	13
3,120	**3,160**	453	384	325	284	242	201	160	119	77	44	17
3,160	**3,200**	463	394	331	290	248	207	166	125	83	48	21
3,200	**3,240**	473	404	337	296	254	213	172	131	89	52	25
3,240	**3,280**	483	414	345	302	260	219	178	137	95	56	29
3,280	**3,320**	493	424	355	308	266	225	184	143	101	60	33
3,320	**3,360**	503	434	365	314	272	231	190	149	107	66	37
3,360	**3,400**	513	444	375	320	278	237	196	155	113	72	41
3,400	**3,440**	523	454	385	326	284	243	202	161	119	78	45
3,440	**3,480**	533	464	395	332	290	249	208	167	125	84	49
3,480	**3,520**	543	474	405	338	296	255	214	173	131	90	53
3,520	**3,560**	553	484	415	346	302	261	220	179	137	96	57
3,560	**3,600**	563	494	425	356	308	267	226	185	143	102	61
3,600	**3,640**	573	504	435	366	314	273	232	191	149	108	67
3,640	**3,680**	583	514	445	376	320	279	238	197	155	114	73
3,680	**3,720**	593	524	455	386	326	285	244	203	161	120	79
3,720	**3,760**	603	534	465	396	332	291	250	209	167	126	85
3,760	**3,800**	613	544	475	406	338	297	256	215	173	132	91
3,800	**3,840**	623	554	485	416	348	303	262	221	179	138	97
3,840	**3,880**	633	564	495	426	358	309	268	227	185	144	103
3,880	**3,920**	643	574	505	436	368	315	274	233	191	150	109
3,920	**3,960**	653	584	515	446	378	321	280	239	197	156	115
3,960	**4,000**	663	594	525	456	388	327	286	245	203	162	121
4,000	**4,040**	673	604	535	466	398	333	292	251	209	168	127
4,040	**4,080**	683	614	545	476	408	339	298	257	215	174	133
4,080	**4,120**	693	624	555	486	418	349	304	263	221	180	139
4,120	**4,160**	703	634	565	496	428	359	310	269	227	186	145
4,160	**4,200**	713	644	575	506	438	369	316	275	233	192	151
4,200	**4,240**	723	654	585	516	448	379	322	281	239	198	157
4,240	**4,280**	733	664	595	526	458	389	328	287	245	204	163
4,280	**4,320**	743	674	605	536	468	399	334	293	251	210	169
4,320	**4,360**	753	684	615	546	478	409	340	299	257	216	175
4,360	**4,400**	763	694	625	556	488	419	350	305	263	222	181
4,400	**4,440**	773	704	635	566	498	429	360	311	269	228	187
4,440	**4,480**	783	714	645	576	508	439	370	317	275	234	193
4,480	**4,520**	793	724	655	586	518	449	380	323	281	240	199
4,520	**4,560**	803	734	665	596	528	459	390	329	287	246	205
4,560	**4,600**	813	744	675	606	538	469	400	335	293	252	211
4,600	**4,640**	823	754	685	616	548	479	410	341	299	258	217
4,640	**4,680**	833	764	695	626	558	489	420	351	305	264	223
4,680	**4,720**	843	774	705	636	568	499	430	361	311	270	229
4,720	**4,760**	853	784	715	646	578	509	440	371	317	276	235
4,760	**4,800**	863	794	725	656	588	519	450	381	323	282	241
4,800	**4,840**	873	804	735	666	598	529	460	391	329	288	247
4,840	**4,880**	883	814	745	676	608	539	470	401	335	294	253
4,880	**4,920**	893	824	755	686	618	549	480	411	343	300	259
4,920	**4,960**	903	834	765	696	628	559	490	421	353	306	265
4,960	**5,000**	913	844	775	706	638	569	500	431	363	312	271
5,000	**5,040**	923	854	785	716	648	579	510	441	373	318	277
5,040	**5,080**	933	864	795	726	658	589	520	451	383	324	283
$5,080 and over		Use Table 4(a) for a **SINGLE person** on page 36. Also see the instructions on page 34.										

MARRIED Persons—**MONTHLY** Payroll Period

(For Wages Paid in 2006)

If the wages are–		And the number of withholding allowances claimed is—										
At least	But less than	0	1	2	3	4	5	6	7	8	9	10
		The amount of income tax to be withheld is—										
$0	**$540**	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
540	**560**	0	0	0	0	0	0	0	0	0	0	0
560	**580**	0	0	0	0	0	0	0	0	0	0	0
580	**600**	0	0	0	0	0	0	0	0	0	0	0
600	**640**	0	0	0	0	0	0	0	0	0	0	0
640	**680**	0	0	0	0	0	0	0	0	0	0	0
680	**720**	3	0	0	0	0	0	0	0	0	0	0
720	**760**	7	0	0	0	0	0	0	0	0	0	0
760	**800**	11	0	0	0	0	0	0	0	0	0	0
800	**840**	15	0	0	0	0	0	0	0	0	0	0
840	**880**	19	0	0	0	0	0	0	0	0	0	0
880	**920**	23	0	0	0	0	0	0	0	0	0	0
920	**960**	27	0	0	0	0	0	0	0	0	0	0
960	**1,000**	31	4	0	0	0	0	0	0	0	0	0
1,000	**1,040**	35	8	0	0	0	0	0	0	0	0	0
1,040	**1,080**	39	12	0	0	0	0	0	0	0	0	0
1,080	**1,120**	43	16	0	0	0	0	0	0	0	0	0
1,120	**1,160**	47	20	0	0	0	0	0	0	0	0	0
1,160	**1,200**	51	24	0	0	0	0	0	0	0	0	0
1,200	**1,240**	55	28	0	0	0	0	0	0	0	0	0
1,240	**1,280**	59	32	4	0	0	0	0	0	0	0	0
1,280	**1,320**	63	36	8	0	0	0	0	0	0	0	0
1,320	**1,360**	67	40	12	0	0	0	0	0	0	0	0
1,360	**1,400**	71	44	16	0	0	0	0	0	0	0	0
1,400	**1,440**	75	48	20	0	0	0	0	0	0	0	0
1,440	**1,480**	79	52	24	0	0	0	0	0	0	0	0
1,480	**1,520**	83	56	28	1	0	0	0	0	0	0	0
1,520	**1,560**	87	60	32	5	0	0	0	0	0	0	0
1,560	**1,600**	91	64	36	9	0	0	0	0	0	0	0
1,600	**1,640**	95	68	40	13	0	0	0	0	0	0	0
1,640	**1,680**	99	72	44	17	0	0	0	0	0	0	0
1,680	**1,720**	103	76	48	21	0	0	0	0	0	0	0
1,720	**1,760**	107	80	52	25	0	0	0	0	0	0	0
1,760	**1,800**	111	84	56	29	1	0	0	0	0	0	0
1,800	**1,840**	115	88	60	33	5	0	0	0	0	0	0
1,840	**1,880**	119	92	64	37	9	0	0	0	0	0	0
1,880	**1,920**	123	96	68	41	13	0	0	0	0	0	0
1,920	**1,960**	129	100	72	45	17	0	0	0	0	0	0
1,960	**2,000**	135	104	76	49	21	0	0	0	0	0	0
2,000	**2,040**	141	108	80	53	25	0	0	0	0	0	0
2,040	**2,080**	147	112	84	57	29	2	0	0	0	0	0
2,080	**2,120**	153	116	88	61	33	6	0	0	0	0	0
2,120	**2,160**	159	120	92	65	37	10	0	0	0	0	0
2,160	**2,200**	165	124	96	69	41	14	0	0	0	0	0
2,200	**2,240**	171	130	100	73	45	18	0	0	0	0	0
2,240	**2,280**	177	136	104	77	49	22	0	0	0	0	0
2,280	**2,320**	183	142	108	81	53	26	0	0	0	0	0
2,320	**2,360**	189	148	112	85	57	30	2	0	0	0	0
2,360	**2,400**	195	154	116	89	61	34	6	0	0	0	0
2,400	**2,440**	201	160	120	93	65	38	10	0	0	0	0
2,440	**2,480**	207	166	124	97	69	42	14	0	0	0	0
2,480	**2,520**	213	172	130	101	73	46	18	0	0	0	0
2,520	**2,560**	219	178	136	105	77	50	22	0	0	0	0
2,560	**2,600**	225	184	142	109	81	54	26	0	0	0	0
2,600	**2,640**	231	190	148	113	85	58	30	3	0	0	0
2,640	**2,680**	237	196	154	117	89	62	34	7	0	0	0
2,680	**2,720**	243	202	160	121	93	66	38	11	0	0	0
2,720	**2,760**	249	208	166	125	97	70	42	15	0	0	0
2,760	**2,800**	255	214	172	131	101	74	46	19	0	0	0
2,800	**2,840**	261	220	178	137	105	78	50	23	0	0	0
2,840	**2,880**	267	226	184	143	109	82	54	27	0	0	0
2,880	**2,920**	273	232	190	149	113	86	58	31	3	0	0
2,920	**2,960**	279	238	196	155	117	90	62	35	7	0	0
2,960	**3,000**	285	244	202	161	121	94	66	39	11	0	0
3,000	**3,040**	291	250	208	167	126	98	70	43	15	0	0
3,040	**3,080**	297	256	214	173	132	102	74	47	19	0	0
3,080	**3,120**	303	262	220	179	138	106	78	51	23	0	0
3,120	**3,160**	309	268	226	185	144	110	82	55	27	0	0
3,160	**3,200**	315	274	232	191	150	114	86	59	31	4	0
3,200	**3,240**	321	280	238	197	156	118	90	63	35	8	0

MARRIED Persons—**MONTHLY** Payroll Period

(For Wages Paid in 2006)

If the wages are–		And the number of withholding allowances claimed is—										
At least	But less than	0	1	2	3	4	5	6	7	8	9	10
		The amount of income tax to be withheld is—										
$3,240	**$3,280**	$327	$286	$244	$203	$162	$122	$94	$67	$39	$12	$0
3,280	**3,320**	333	292	250	209	168	127	98	71	43	16	0
3,320	**3,360**	339	298	256	215	174	133	102	75	47	20	0
3,360	**3,400**	345	304	262	221	180	139	106	79	51	24	0
3,400	**3,440**	351	310	268	227	186	145	110	83	55	28	0
3,440	**3,480**	357	316	274	233	192	151	114	87	59	32	4
3,480	**3,520**	363	322	280	239	198	157	118	91	63	36	8
3,520	**3,560**	369	328	286	245	204	163	122	95	67	40	12
3,560	**3,600**	375	334	292	251	210	169	127	99	71	44	16
3,600	**3,640**	381	340	298	257	216	175	133	103	75	48	20
3,640	**3,680**	387	346	304	263	222	181	139	107	79	52	24
3,680	**3,720**	393	352	310	269	228	187	145	111	83	56	28
3,720	**3,760**	399	358	316	275	234	193	151	115	87	60	32
3,760	**3,800**	405	364	322	281	240	199	157	119	91	64	36
3,800	**3,840**	411	370	328	287	246	205	163	123	95	68	40
3,840	**3,880**	417	376	334	293	252	211	169	128	99	72	44
3,880	**3,920**	423	382	340	299	258	217	175	134	103	76	48
3,920	**3,960**	429	388	346	305	264	223	181	140	107	80	52
3,960	**4,000**	435	394	352	311	270	229	187	146	111	84	56
4,000	**4,040**	441	400	358	317	276	235	193	152	115	88	60
4,040	**4,080**	447	406	364	323	282	241	199	158	119	92	64
4,080	**4,120**	453	412	370	329	288	247	205	164	123	96	68
4,120	**4,160**	459	418	376	335	294	253	211	170	129	100	72
4,160	**4,200**	465	424	382	341	300	259	217	176	135	104	76
4,200	**4,240**	471	430	388	347	306	265	223	182	141	108	80
4,240	**4,280**	477	436	394	353	312	271	229	188	147	112	84
4,280	**4,320**	483	442	400	359	318	277	235	194	153	116	88
4,320	**4,360**	489	448	406	365	324	283	241	200	159	120	92
4,360	**4,400**	495	454	412	371	330	289	247	206	165	124	96
4,400	**4,440**	501	460	418	377	336	295	253	212	171	130	100
4,440	**4,480**	507	466	424	383	342	301	259	218	177	136	104
4,480	**4,520**	513	472	430	389	348	307	265	224	183	142	108
4,520	**4,560**	519	478	436	395	354	313	271	230	189	148	112
4,560	**4,600**	525	484	442	401	360	319	277	236	195	154	116
4,600	**4,640**	531	490	448	407	366	325	283	242	201	160	120
4,640	**4,680**	537	496	454	413	372	331	289	248	207	166	124
4,680	**4,720**	543	502	460	419	378	337	295	254	213	172	130
4,720	**4,760**	549	508	466	425	384	343	301	260	219	178	136
4,760	**4,800**	555	514	472	431	390	349	307	266	225	184	142
4,800	**4,840**	561	520	478	437	396	355	313	272	231	190	148
4,840	**4,880**	567	526	484	443	402	361	319	278	237	196	154
4,880	**4,920**	573	532	490	449	408	367	325	284	243	202	160
4,920	**4,960**	579	538	496	455	414	373	331	290	249	208	166
4,960	**5,000**	585	544	502	461	420	379	337	296	255	214	172
5,000	**5,040**	591	550	508	467	426	385	343	302	261	220	178
5,040	**5,080**	597	556	514	473	432	391	349	308	267	226	184
5,080	**5,120**	603	562	520	479	438	397	355	314	273	232	190
5,120	**5,160**	609	568	526	485	444	403	361	320	279	238	196
5,160	**5,200**	615	574	532	491	450	409	367	326	285	244	202
5,200	**5,240**	621	580	538	497	456	415	373	332	291	250	208
5,240	**5,280**	627	586	544	503	462	421	379	338	297	256	214
5,280	**5,320**	633	592	550	509	468	427	385	344	303	262	220
5,320	**5,360**	639	598	556	515	474	433	391	350	309	268	226
5,360	**5,400**	645	604	562	521	480	439	397	356	315	274	232
5,400	**5,440**	651	610	568	527	486	445	403	362	321	280	238
5,440	**5,480**	657	616	574	533	492	451	409	368	327	286	244
5,480	**5,520**	663	622	580	539	498	457	415	374	333	292	250
5,520	**5,560**	669	628	586	545	504	463	421	380	339	298	256
5,560	**5,600**	675	634	592	551	510	469	427	386	345	304	262
5,600	**5,640**	681	640	598	557	516	475	433	392	351	310	268
5,640	**5,680**	687	646	604	563	522	481	439	398	357	316	274
5,680	**5,720**	696	652	610	569	528	487	445	404	363	322	280
5,720	**5,760**	706	658	616	575	534	493	451	410	369	328	286
5,760	**5,800**	716	664	622	581	540	499	457	416	375	334	292
5,800	**5,840**	726	670	628	587	546	505	463	422	381	340	298
5,840	**5,880**	736	676	634	593	552	511	469	428	387	346	304

$5,880 and over Use Table 4(b) for a **MARRIED person** on page 36. Also see the instructions on page 34.

DAKOTA PLAN & DAKOTA RETIREE PLAN

This contains information regarding the Dakota Plan and Dakota Retiree Plan. Both plans are underwritten by Blue Cross Blue Shield of North Dakota (BCBSND). Please refer to the Certificate of Insurance for complete details.

ELIGIBILITY

To be eligible to join the Dakota Plan or the Dakota Retiree Plan:

A member must be receiving a "retirement allowance" from:

- North Dakota Public Employees Retirement System (NDPERS)
  - Defined Benefit Plan
  - Defined Contribution Plan
- North Dakota Highway Patrol Retirement System (NDHPRS)
- Job Service Retirement Plan
- Teacher's Fund for Retirement (TFFR)
- Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-CREF) (North Dakota State University System only)

A member of certain Political Subdivisions, if enrolled in the Dakota Plan as an active employee, and:

- Receiving a "retirement allowance" from a NDPERS Board approved employer sponsored retirement plan, such as:

  - 401(a)
  - 401(k)
  - 403(b)
  - 457

A surviving spouse must be:

- Receiving a beneficiary benefit from the aforementioned retirement plans, or
- On the Dakota Plan as a covered dependent at the time of member's death and there is no lapse in coverage.

A non-spouse beneficiary is not eligible to continue on the group health plan.

ENROLLMENT

A member or surviving spouse must apply within 31 days from any one of the following "qualifying events":

1. Date of retirement, defined as either:

   - The last day of active employment if member does not defer his/her retirement benefit or take a lump-sum refund of his/her retirement account, or
   - Date of first retirement check if member deferred his/her retirement benefit.

2. Member's 65th birthday or eligibility for Medicare;

3. Member's spouse or eligible dependent's 65th birthday or eligibility for Medicare;

4. The loss of coverage in a health plan sponsored or provided by member's employer or member's spouse's employer, if covered through spouse's employer group plan. This includes loss of coverage due to the death of, or divorce from a spouse as well as completion of COBRA continuation coverage.

5. Marriage

6. Birth, adoption, or appointment of children for legal guardianship.

If a member or surviving spouse does not enroll within 31 days of any one of the above qualifying events, he/she will have forfeited his/her rights to enroll in the Plan in the future.

COVERAGE EFFECTIVE DATE

If a member is enrolled in the Dakota Plan as an active employee, coverage will become effective on the first of the month following the final date of coverage provided by his/her employer. If a member was not enrolled in the Dakota Plan at the time of application, coverage will become effective on the first day of the month following one of the "qualifying events" listed above.

PREMIUM PAYMENT POLICY

Retirement Plan	Payment Method
NDPERS Defined Benefit[1]	Benefit Check Bank Account
NDPERS Defined Contribution[3]	Bank Account
NDHPRS[1]	Benefit Check Bank Account
Job Service[1]	Benefit Check Bank Account
TFFR[2]	Benefit Check Bank Account
TIAA-CREF[3]	Bank Account
Approved Employer Sponsored[3]	Bank Account

1. If retirement allowance is large enough to deduct the entire monthly premium, the premium will automatically be withheld from the benefit check. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50131. It is the policy of NDPERS that a member's net annuity payment cannot be less than $25.00.

2. If TFFR retirement allowance is large enough to deduct the entire monthly premium, an election to have premiums withheld from a benefit check must be made. Complete an Payroll Deduction Authorization (313) SFN 19182. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50131. It is the policy of NDPERS that a member's net annuity payment can not be less than $25.00.

3. If retirement allowance is issued from the NDPERS Defined Contribution plan, TIAA-CREF, or a Board approved employer sponsored retirement plan, premiums must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50131. It is the policy of NDPERS that a member's net annuity payment can not be less than $25.00.

CANCELLATION POLICY

To cancel NDPERS health coverage, a written request must be submitted. The request must provide the contract holder's name, contract number and effective date. NDPERS must receive a cancellation request by the **15th** of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

DAKOTA PLAN

COBRA CONTINUATION

A member is eligible for COBRA continuation if enrolled in the Dakota Plan as an active employee and is not eligible for Medicare. A member will have the option to continue coverage for 18 months under COBRA or until eligible for Medicare, whichever occurs first. Options will vary based on the following:

- A member **deferred his/her retirement allowance or took a lump sum payment** of retirement account. After the 18 months has expired and if member is not yet receiving a retirement allowance from one of the eligible retirement systems listed previously, he/she has the option to enroll under a conversion health plan. For details about the conversion option, contact BCBSND at 1-800-223-1704 or (701) 282-1400 in the Fargo area.

- A member elects to begin receiving **a retirement allowance immediately** from an eligible retirement system. At the conclusion of the 18 months or when member or eligible dependent becomes eligible for Medicare, the option to enroll in the "Dakota Plan" or the "Dakota Retiree Plan" becomes available, subject to the eligibility requirements.

The following COBRA premiums are in effect through June 30, 2007:

	Single	Family
State Agencies	$266.18	$656.50
Political Subdivisions, enrolled prior to July 1, 2005	$284.64	$702.01
Political Subdivisions, enrolled after July 1, 2005*	$287.27	$691.74
EPO Only Groups, enrolled prior to July 1, 2005	$264.39	$652.26
EPO Only Groups, enrolled after July 1, 2005*	$267.44	$643.74

*Subject to rate increases July 1, 2006

END OF COBRA PERIOD OR NEW COVERAGE

If eligibility continues upon completion of COBRA or member is applying for new coverage, the following premiums are in effect through June 30, 2007:

	Single	Family
Non-Medicare	$390.92	$781.86
Non-Medicare (3 or more)		$977.32

EXTENDED COBRA

Disability

A member or their dependent determined to have been disabled for Social Security purposes may extend the continuation of coverage to 29 months. If member or their dependent becomes disabled at any time during the first 60 days of COBRA continuation coverage the member must provide notice of such determination to NDPERS within 60 days after the date of any final determination of disability and before the end of the 18 month continuation period.

Death

Continuation of coverage may be extended for a period up to 36 months for a eligible dependent.

CANCELLATION OF COBRA

Coverage may be cancelled when a person receiving continuation of coverage becomes covered under another benefit plan providing the same or similar coverage.

DAKOTA PLAN FEATURES

Preferred Provider Organization (PPO) - is a group of hospitals, clinics and physicians who have agreed to discount their services to members of NDPERS. You have "freedom of choice" in selecting which physician or medical facility to use for services. No referral is needed. If you choose a provider who participates in the PPO program, you will have lower out-of-pocket expenses. PPO benefits are only available in the State of North Dakota, unless the medical facility provides services at a satellite location in another State.

Exclusive Provider Organization (EPO) – is a managed care program and encourages the use of a Primary Care Physician. You and each of your eligible family members may use any Primary Care Physician affiliated with your designated EPO provider. You may change your Primary Care Physicians at any time. The medical practices included under primary care are: General/Family Practice, Obstetrics/Gynecology, Pediatrics and Internal Medicine. If you enroll in the EPO you will have lower out-of-pocket expenses for annual deductibles and reduced copayments for office visits and diagnostic services. Your affiliation is for one year and you must reside in a 50 mile radius of an EPO provider. The plan year runs from July 1 through June 30 of the following year.
EPO coverage is only available to retirees that participated in the program as an active employee. EPO coverage terminates upon completion of COBRA or entitlement to Medicare, whichever occurs first.

Plan Features:	Basic (Self Referral or Out-of-State)	PPO	EPO*
Deductible for All Services			
-Per Person	$250	$250	$100
-Per Family	$750	$750	$300
Copayment for Physician Office Visits (no limit)	$ 25	$ 20	$ 15
Copayment for Emergency Room	$ 50	$ 50	$ 50
Coinsurance on all covered services EXCEPT Physician Office Visits	75/25	80/20	85/15
Annual Coinsurance Maximum			
-Individual	$1250	$750	$500
-Family	$2500	$1500	$1000
Out-of-Pocket Maximums (Deductible and Coinsurance)**			
-Individual	$1500	$1000	$600
-Family	$3250	$2250	$1300

* Out-of-network coverage is at the Basic level.

**Office visit and emergency room copayments and prescription drug copayments and coinsurance are additional.

DEDUCTIBLE AND COINSURANCE

Deductible, copayments, and coinsurance maximums accrue on a "Calendar-Year" basis, January 1 - December 31.

Plan Features:	Basic (Self Referral or Out-of-State)	PPO	EPO*
Prescription Formulary Generic Drug			
-Copayment	$5	$5	$5
- Coinsurance ($1,000 maximum per person per benefit period, covered at 100% after $1,000 maximum is met)	15%	15%	15%
Prescription Formulary Brand-Name Drug***			
-Copayment	$15	$15	$15
- Coinsurance ($1,000 maximum per person per benefit period, covered at 100% after $1,000 maximum is met)	25%	25%	25%
Prescription Non-Formulary Drug			
-Copayment	$25	$25	$25
-Coinsurance	50%	50%	50%

*** For each 34-day supply or 100 units of an authorized maintenance drug or non-prescription diabetic supplies.

MAIL ORDER PRESCRIPTION DRUGS

Please contact BCBSND at 1-800-223-1704.

PREVENTIVE SCREENING SERVICES

The following services are paid at 100% of allowed charge. The deductible amount is waived.

PREVENTATIVE SCREENING	
Members Age and Benefits Schedule	***PPO and Basic***
Members age 19 – 39 receive once every five (5) years	Fecal Occult Blood Testing, Total Serum Cholesterol Testing, Blood Sugar Testing
Members age 40 – 49 receive once every two (2) years	Fecal Occult Blood Testing
Members age 40 – 64 receive once every two (2) years	Total Serum Cholesterol Testing, Blood Sugar Testing
Members age 50 and older receive once per benefit period	Fecal Occult Blood Testing
Members age 65 and older receive once per benefit period	Total Serum Cholesterol Testing, Blood Sugar Testing

DAKOTA RETIREE PLAN

The Dakota Retiree Plan is a "Carve-Out" plan that pays secondary to Medicare. It is not a supplemental plan. As secondary payer, there will be an adjustment to the premium if transitioning from the Dakota Plan.

A member or eligible dependent is eligible to enroll in this health coverage at the time of Medicare eligibility. If covered under the Dakota Plan at the time, a member will receive a notification approximately 60 days prior to the eligibility date regarding the enrollment procedures. To enroll, the following requirements must be complied with:

- The eligible member(s)/dependent(s) must have both parts A and B of Medicare. If the eligible member(s)/dependent(s) continues to be covered by an "active" employer group policy, Medicare Part B may be waived until the contract holder terminates employment.

- The eligible member(s)/dependent(s) must complete the Retiree Group Health Insurance Application as well as a Medicare Blue Rx Application for each person who is Medicare eligible and also include a copy of the Medicare card.

If the above requirements are met and member enrolled prior to July 1, 2005, the following premiums are in effect through December 31, 2006:

	Single	Family*
One Medicare/One Non-Medicare		$488.90
Medicare Eligible (must have both Medicare A & B)	$169.40	$329.24

If the above requirements are met and member enrolled in the plan on or after July 1, 2005 the following premiums are in effect through June 30, 2006 [See rates below for July 1, 2006 through December 31, 2006]:

	Single	Family*
One Medicare/One Non-Medicare		$499.44
Medicare Eligible (must have both Medicare A & B)	$174.72	$337.98

If the above requirements are met and member enrolled in the plan on or after July 1, 2006 the following premiums are in effect through December 31, 2006:

	Single	Family*
One Medicare/One Non-Medicare		$559.76
Medicare Eligible (must have both Medicare A & B)	$199.32	$385.92

***NOTE:** If you have more than two people on your health insurance policy, please contact NDPERS for your rate.

If member/dependent did not enroll in the plan at the time he/she is eligible, coverage will cease on the first day of the month in which the member or dependent(s) became eligible.

DAKOTA RETIREE PLAN

The "Dakota Retiree Plan" provides health care coverage as a secondary payer to Medicare. The "Dakota Retiree Plan" differs from the regular Federal Supplement plans A through J in that it does not pay 100% of the balance of Medicare's approved charges. The following is a brief description of benefits as provided by the plan when paying secondary to Medicare. Please note that the "Dakota Retiree Plan" provides you with prescription drug coverage. To continue coverage with the NDPERS Dakota Retiree Plan you must carry both Parts A and B of Medicare when you become eligible for Medicare benefits. If you or your spouse/dependent are eligible for Medicare but continue to be covered by an "active" employer group policy, Medicare Part B may be waived until the contract holder terminates from employment.

TYPE OF SERVICE	*MEDICARE PAYS*	*DAKOTA RETIREE PLAN PAYS*	
		In State PPO Provider	Non PPO Provider or Out of State
INPATIENT HOSPITAL SERVICES Includes semi-private room and board, general nursing and miscellaneous hospital services and supplies.	A benefit period begins on the first day you receive service as an impatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. The following is based on a benefit period. First 60 days : all but $952 61st thru 90th day : all but $2,389 a day 91st day and after : all but $476 a day	Dakota Plan pays 80% after the annual $250 deductible. For any subsequent illness where Medicare's deductible is applied again, Dakota Plan pays 80%.	Dakota Plan pays 75% after the annual $250 deductible. For any subsequent illness where Medicare'' deductible is applied again, Dakota Plan pays 75%.
OUTPATIENT HOSPITAL SERVICES & SUPPLIES Includes services for first-aid emergency care, laboratory and x-ray tests, surgical procedures, radiation therapy, home health visits, ambulance, and durable medical equipment such as oxygen equipment and wheelchairs.	Outpatient services are covered when provided for and billed by a hospital, subject to the Medicare Part B annual $124 deductible and 20% coinsurance	Dakota Plan pays eligible expenses at 80%, subject to an annual $250 deductible (combined with inpatient services).	Dakota Plan pays eligible expenses at 75%, subject to an annual $250 deductible (combined with inpatient services).
EXTENDED CARE/HOME HEALTH	Skilled Nursing Facility – In each benefit period, Medicare Part A may pay for all covered services for the first 20 days you are in a skilled nursing facility. For the 21st – 100th day, Medicare Part A copayment is $114 per day. Home Health Care – Unlimited home health visits if all Medicare guidelines have been met.	Unlimited days for Skilled Nursing Facilities and Home Health Care for medically necessary (skilled) services paid at 80%, subject to an annual $250 deductible (combined with in-outpatient services). No coverage for intermediate and/or custodial care.	Unlimited days for Skilled Nursing Facilities and Home Health Care for medically necessary (skilled) services paid at 75%, subject to an annual $250 deductible (combined with in-outpatient services). No coverage for intermediate and/or custodial care.
AVAILABLE PHYSICIAN, MEDICAL SERVICES AND SUPPLIES Includes physician services wherever provided – in-home, hospital, or office; diagnostic x-ray and lab tests; physical and speech therapy; medical supplies such as splints and casts, certain prosthetic devices; artificial limbs and eyes.	You pay the first $124 per year – Medicare Part B (medical insurance) then pays 80% of the remaining allowable charges for covered services as determined by Medicare Part B.	Dakota Plan pays 80% of allowable charges on Medicare's balance.	Dakota Plan pays 75% of allowable charges on Medicare's balance.
PRESCRIPTION DRUGS	Inpatient prescription drugs only. No coverage for outpatient prescription drugs unless enrolled in Medicare Part D.	Prescription Drugs – Retail and mail order for each 34 day supply or 100 units of an authorized maintenance drug: **Formulary:** **Copayment** **Co-insurance** Brand-name drug charge* $15 25% of allowable Generic drug charge* $ 5 15% of allowable *After yearly out-of-pocket drug costs reach $3,600 you pay $2 for generic or a preferred brand name drug that is a multi-source drug and $5 for all other drugs or 5% coinsurance. Non-Formulary: **$25** **50% of allowable charge** Members pay the difference between generic and brand-name price if brand-name drug is purchased and generic is available.	

North Dakota
Public Employees Retirement System
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NDPERS RETIREE NOTICE (11/01/05)

Important Notice from the North Dakota Public Employees Retirement System About Your Prescription Drug Coverage and Medicare

PLEASE READ THIS ENTIRE NOTICE CAREFULLY before making a decision about your prescription drug coverage. Starting January 1, 2006, new Medicare prescription drug coverage will be available to everyone with Medicare. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare.

Because it has been determined that your existing coverage is on average at least as good as the standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

Individuals with Medicare can enroll in a Medicare prescription drug plan from November 15, 2005 through May 15, 2006. However, because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later without paying late enrollment penalties. In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will not be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan. **Before making your decision, please examine all your options to be sure you understand the plan coverages.**

If you do decide to enroll in a Medicare Prescription drug plan you must drop your NDPERS coverage. Be aware that you may not be able to get this coverage back.

If you drop your current coverage, you will only be able to re-enroll if you apply for coverage within 31 days from any one of the following "qualifying events":

1. Date of retirement, defined as either:

   The last day of active employment if member does not defer his/her retirement benefit or take a lump-sum refund of his/her retirement account, or

   Date of first retirement check if member deferred his/her retirement benefit.
2. Member's 65th birthday or eligibility for Medicare;
3. Member's spouse or eligible dependent's 65th birthday or eligibility for Medicare;
4. The loss of coverage in a health plan sponsored or provided by member's employer or member's spouse's employer, if covered through spouse's employer group plan. This includes loss of coverage due to the death of, or divorce from a spouse as well as completion of COBRA continuation coverage.
5. Marriage
6. Birth, adoption, or appointment of children for legal guardianship.

At this point you have two choices.

1) You can maintain your current health insurance coverage with NDPERS which provides coverage for all your health insurance expenses including prescription drug coverage. If that is what you choose to do you do not have to do anything. NDPERS will automatically enroll you in our new Prescription Drug

Program (PDP) effective January 1, 2006. **Additional information pertaining to the coverage and premium cost will be provided sometime in late November**. Or,

2) You can choose to drop the NDPERS health insurance coverage and enroll in Medicare Part D and also enroll in an alternate Medicare Supplemental Plan. To cancel NDPERS health coverage, a written request must be submitted. The request must provide the contract holder's name, contract number and effective date. NDPERS must receive a cancellation request by the 15th of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

NOTE: If you choose to continue NDPERS coverage, you are not allowed to enroll in a separate Medicare Part D drug plan.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You 2006" handbook. You should have already received a copy of the handbook in the mail from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from the following resources:

- Visit www.medicare.gov for personalized help,
- Call Senior Health Insurance Counseling (SHIC), a program of the North Dakota Insurance Department, at 1-800-247-0560, or
- Call 1-800-MEDICARE (1-800-325-4227). TTY users should call 1-877-486-2048.

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage after May 15, 2006, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

DEFINITIONS

CLASS OF COVERAGE - the type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Classes of Coverage are as follows:

A. Single Coverage - Subscriber only.
B. Family Coverage - Subscriber and Eligible Dependents.

ELIGIBLE DEPENDENT - a dependent of the Subscriber who qualifies for membership under this Benefit Plan in accordance with the requirements specified below:

A. The Subscriber's spouse under a legally existing marriage between persons of the opposite sex.
B. The Subscriber's or the Subscriber's living, covered spouse's unmarried children under the age of 23 years who are financially dependent on the Subscriber or the Subscriber's spouse. Children are considered under age 23 until the end of the month in which the child becomes 23 years of age. The term child or children includes:
C.
    1. Children physically placed with the Subscriber for adoption or whom the Subscriber or the Subscriber's living, covered spouse has legally adopted.
    2. Children living with the Subscriber for whom the Subscriber or the Subscriber's living, covered spouse has been appointed legal guardian by court order.
    3. The Subscriber's grandchildren or those of the Subscriber's living, covered spouse if: (a) the parent of the grandchild is a covered Eligible Dependent under this Benefit Plan and (b) both the parent and the grandchild are primarily dependent on the Subscriber for support. If a lapse in coverage occurs due to ineligibility of the parent under this Benefit Plan, the grandchild cannot be reenrolled unless the Subscriber has been appointed legal guardian.
    4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits.
    5. Children beyond the age of 23 who are full-time students at accredited institutions who are financially dependent on the Subscriber or the Subscriber's spouse. Coverage in such cases will be continued only until the end of the month in which the child becomes 26 years of age.
    6. Children beyond the age of 23 who are incapable of self support because of mental retardation or physical handicap that began before the child attained age 23 and who are primarily dependent on the Subscriber or the Subscriber's spouse for support. Coverage for such a disabled child will continue for as long as the child remains unmarried, disabled and the Subscriber's dependent for federal income tax purposes. The Subscriber may be asked periodically to provide evidence satisfactory to BCBSND of these disabilities.

A Member will in no event be an Eligible Dependent of more than one employee. A dependent of an employee will not be eligible if that dependent is also an employee.

MEMBER - the Subscriber and, if another Class of Coverage is in force, the Subscriber's Eligible Dependents.

PAY STATUS - a Subscriber/surviving spouse receiving a retirement allowance from an eligible retirement plan.

RETIREE – a Subscriber receiving a monthly retirement allowance pursuant to chapter 54-52.

RETIREMENT - the acceptance of a retirement allowance upon either termination of employment or termination of participation in the retirement plan and meeting the normal retirement date.

RETIREMENT ALLOWANCE- a reoccurring, periodic benefit from an eligible employer sponsored retirement plan.

SURVIVING SPOUSE - a legal spouse of the deceased member.

SUBSCRIBER - the individual whose application for membership has been accepted, whose coverage is in force with BCBSND and in whose name the Identification Card and Benefit Plan Attachment are issued.

LIFE INSURANCE

Effective July 1, 2005

If you are participating in the NDPERS group life insurance plan as an active employee, you will have the option to continue your employee supplemental, dependent supplemental, and spouse supplemental life insurance coverage to age 65. This election must be made within 31 days of date of retirement by completing a Retiree Life Insurance Application SFN 53622. If you do not apply to continue coverage during this time limit, you will have forfeited your right to enroll in the future.

You may either maintain the same level(s) of coverage you had as an active employee or elect to decrease or discontinue your level(s) of coverage. You cannot increase any coverage levels, apply for coverage you are not participating in at the time of retirement, nor are you eligible for the annual enrollment.

Life insurance premiums may be paid on the same basis as the health premium; by deduction from the pension check, deduction from a bank account, or by individual billing. However, if you are also participating in the health plan, the life premium must be paid in the same manner as that selected for the health premium. Premiums can not be withheld from a retirement benefit as a pre-tax deduction.

The employee supplemental, dependent life, and spouse supplemental insurance will terminate at age 65. You are eligible to continue the $1,300 basic coverage for life (cost = $4.32). However, to continue any other levels of coverage, you will be given the opportunity to convert to an individual life policy with the life insurance. You or your insured dependent may convert this insurance by applying and paying the first premium for an individual policy within 31 days after any part of your or your insured dependent's insurance stops. Prudential or the Policyholder must be notified by completing a Life Conversion Information Request Form.

Refer to your Life Insurance Plan Handbook for further details on the Life Insurance benefits.

WAIVER OF PREMIUM DISABILITY CLAIM

If you participate in the NDPERS group life insurance plan as an active employee, you may continue your basic and employee supplemental life insurance coverage. To be eligible to continue your coverage, you must be under age 60, receiving a monthly disability benefit from NDPERS, and apply for a wavier of premium within one year from the date total disability begins. If you do not apply for a waiver of premium, only the $1,300 of basic life coverage may be continued and it will be at your own expense.

To apply for a waiver, you and your employer must complete and file a Prudential Group Life Claim for Total Disability Benefits Form GL.2003.0151. Your physician must complete a Prudential Group Life Benefit Attending Physician Statement Form GL.2002.1191. The completed forms must be returned to NDPERS who will forward them to the Life Insurance Company. You will be notified in writing whether or not the waiver has been approved. If approved, the premium is waived for the amount of life insurance you had on the day total disability began and your coverage will be continued until age 65. After age 65, you can elect to continue your $1,300 of basic coverage at your own expense.

You or your insured dependent may convert to an individual life insurance policy if any part of you or your insured dependents life insurance under the group policy stops.

Retiree Supplemental Life and Accidental Death and Dismemberment Insurance

Monthly Premium Amounts – Underwritten by Prudential

Rates Effective July 1, 2005

$1,300 Basic = $4.32

Employee's Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
40 to 44	$4.84	$5.54	$6.24	$6.94	$7.64	$8.34	$9.04	$9.74	$10.44	$11.14
45 to 49	$4.99	$5.89	$6.79	$7.69	$8.59	$9.49	$10.39	$11.29	$12.19	$13.09
50 to 54	$5.28	$6.58	$7.88	$9.18	$10.48	$11.78	$13.08	$14.38	$15.68	$16.98
55 to 59	$6.17	$8.67	$11.17	$13.67	$16.17	$18.67	$21.17	$23.67	$26.17	$28.67
60 to 64	$7.13	$10.93	$14.73	$18.53	$22.33	$26.13	$29.93	$33.73	$37.53	$41.33

Employee Total Coverage (Including Basic)

Employee's Age	$55,000	$60,000	$65,000	$70,000	$75,000	$80,000	$85,000	$90,000	$95,000	$100,000
40 to 44	$11.84	$12.54	$13.24	$13.94	$14.64	$15.34	$16.04	$16.74	$17.44	$18.14
45 to 49	$13.99	$14.89	$15.79	$16.69	$17.59	$18.49	$19.39	$20.29	$21.19	$22.09
50 to 54	$18.28	$19.58	$20.88	$22.18	$23.48	$24.78	$26.08	$27.38	$28.68	$29.98
55 to 59	$31.17	$33.67	$36.17	$38.67	$41.17	$43.67	$46.17	$48.67	$51.17	$53.67
60 to 64	$45.13	$48.93	$52.73	$56.53	$60.33	$64.13	$67.93	$71.73	$75.53	$79.33

Employee Total Coverage (Including Basic)

Employee's Age	$105,000	$110,000	$115,000	$120,000	$125,000	$130,000	$135,000	$140,000	$145,000	$150,000
40 to 44	$18.84	$19.54	$20.24	$20.94	$21.64	$22.34	$23.04	$23.74	$24.44	$25.14
45 to 49	$22.99	$23.89	$24.79	$25.69	$26.59	$27.49	$28.39	$29.29	$30.19	$31.09
50 to 54	$31.28	$32.58	$33.88	$35.18	$36.48	$37.78	$39.08	$40.38	$41.68	$42.98
55 to 59	$56.17	$58.67	$61.17	$63.67	$66.17	$68.67	$71.17	$73.67	$76.17	$78.67
60 to 64	$83.13	$86.93	$90.73	$94.53	$98.33	$102.13	$105.93	$109.73	$113.53	$117.33

Employee Total Coverage (Including Basic)

Employee's Age	$155,000	$160,000	$165,000	$170,000	$175,000	$180,000	$185,000	$190,000	$195,000	$200,000
40 to 44	$25.84	$26.54	$27.24	$27.94	$28.64	$29.34	$30.04	$30.74	$31.44	$32.14
45 to 49	$31.99	$32.89	$33.79	$34.69	$35.59	$36.49	$37.39	$38.29	$39.19	$40.09
50 to 54	$44.28	$45.58	$46.88	$48.18	$49.48	$50.78	$52.08	$53.38	$54.68	$55.98
55 to 59	$81.17	$83.67	$86.17	$88.67	$91.17	$93.67	$96.17	$98.67	$101.17	$103.67
60 to 64	$121.13	$124.93	$128.73	$132.53	$136.33	$140.13	$143.93	$147.73	$151.53	$155.33

Dependent Supplemental Life Insurance Premiums

Monthly Premium Amounts

Rates Effective July 1, 2005

Employee Age	Total Coverage $2,000	$5,000
40 to 44	$0.24	$0.60
45 to 49	$0.24	$0.60
50 to 54	$0.24	$0.60
55 to 59	$0.24	$0.60
60 to 64	$0.24	$0.60

Spouse Supplemental Life Insurance

Monthly Premium Amounts

Rates Effective July 1, 2005

Spouse Total Coverage

Employee's Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
40 to 44	$0.60	$1.20	$1.80	$2.40	$3.00	$3.60	$4.20	$4.80	$5.40	$6.00
45 to 49	$0.90	$1.80	$2.70	$3.60	$4.50	$5.40	$6.30	$7.20	$8.10	$9.00
50 to 54	$1.30	$2.60	$3.90	$5.20	$6.50	$7.80	$9.10	$10.40	$11.70	$13.00
55 to 59	$2.50	$5.00	$7.50	$10.00	$12.50	$15.00	$17.50	$20.00	$22.50	$25.00
60 to 64	$3.80	$ 7.60	$11.40	$15.20	$19.00	$22.80	$26.60	$30.40	$34.20	$38.00

Spouse Total Coverage

Employee's Age	$55,000	$60,000	$65,000	$70,000	$75,000	$80,000	$85,000	$90,000	$95,000	$100,000
40 to 44	$6.60	$7.20	$7.80	$8.40	$9.00	$9.60	$10.20	$10.80	$11.40	$12.00
45 to 49	$9.90	$10.80	$11.70	$12.60	$13.50	$14.40	$15.30	$16.20	$17.10	$18.00
50 to 54	$14.30	$15.60	$16.90	$18.20	$19.50	$20.80	$22.10	$23.40	$24.70	$26.00
55 to 59	$27.50	$30.00	$32.50	$35.00	$37.50	$40.00	$42.50	$45.00	$47.50	$50.00
60 to 64	$ 41.80	$45.60	$49.40	$53.20	$57.00	$60.80	$64.60	$68.40	$72.20	$76.00

RETIREE DENTAL COVERAGE

The group dental plan is available to retired employees and surviving spouses that are receiving a retirement benefit from North Dakota Public Employees Retirement System (NDPERS), TIAA-CREF, ND Teachers Fund For Retirement (TFFR), or Job Service Retirement plan. This coverage allows you to choose your own dentist. The plan highlights and the current premium rates are included for your information.

Retirees or surviving spouse may elect to enroll in the dental plan within 31 days of a "qualifying event." The "qualifying events" are as follows:

ELIGIBILITY

To be eligible to join the Dental Plan:

A member must be receiving a "retirement allowance" from:

- North Dakota Public Employees Retirement System (NDPERS)
  - Defined Benefit Plan
  - Defined Contribution Plan
- North Dakota Highway Patrol Retirement System (NDHPRS)
- Job Service Retirement Plan
- Teacher's Fund for Retirement (TFFR)
- Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-CREF) (North Dakota University System only)

A surviving spouse must be:

- Receiving a beneficiary benefit from the aforementioned retirement plans, or
- On the Dental Plan as a covered dependent at the time of member's death and there is no lapse in coverage.

A non-spouse beneficiary is not eligible to continue on the group dental plan.

ENROLLMENT

A member or surviving spouse must apply within 31 days from any one of the following "qualifying events":

1. Date of retirement, defined as either:

   - The last day of active employment if member does not defer his/her retirement benefit or take a lump-sum refund of his/her retirement account, or
   - Date of first retirement check if member deferred his/her retirement benefit.

2. Members 65th birthday or eligibility for Medicare;

3. Members spouse 65th birthday or eligibility for Medicare;

4. The loss of coverage in a dental plan sponsored or provided by member's employer or member's spouse's employer, if covered through spouse's employer group plan. This includes loss of coverage due to the death of, or divorce from a spouse as well as completion of COBRA continuation coverage.

5. Marriage

6. Birth, adoption, or appointment of children for legal guardianship.

If a member or surviving spouse does not enroll within 31 days of any one of the above qualifying events, he/she will have forfeited his/her rights to enroll in the Plan in the future.

COVERAGE EFFECTIVE DATE

If a member is enrolled in the Dental Plan as an active employee, coverage will become effective on the first of the month following the final date of coverage provided by his/her employer. If a member was not enrolled in the Dental Plan at the time of application, coverage will become effective on the first day of the month following one of the "qualifying events" listed above.

PREMIUM PAYMENT POLICY

Retirement Plan	Payment Method
NDPERS Defined Benefit[1]	Benefit Check Bank Account
NDPERS Defined Contribution[3]	Bank Account
NDHPRS[1]	Benefit Check Bank Account
Job Service[1]	Benefit Check Bank Account
TFFR[2]	Benefit Check Bank Account
TIAA-CREF[3]	Bank Account
Approved Employer Sponsored[3]	Bank Account

1. If retirement allowance is large enough to deduct the entire monthly premium, the premium will automatically be withheld from the benefit check. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50131. It is the policy of NDPERS that a member's net annuity payment can not be less than $25.00.

2. If TFFR retirement allowance is large enough to deduct the entire monthly premium, an election to have premiums withheld from a benefit check must be made. Complete an Payroll Deduction Authorization (313) SFN 19182. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50131. It is the policy of NDPERS that a member's net annuity payment can not be less than $25.00.

3. If retirement allowance is issued from the NDPERS Defined Contribution plan, TIAA-CREF, or a Board approved employer sponsored retirement plan, premiums must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50131. It is the policy of NDPERS that a member's net annuity payment can not be less than $25.00.

CANCELLATION POLICY

To cancel NDPERS dental coverage, a written request must be submitted. The request must provide the contract holder's name, social security number and effective date. NDPERS must receive a cancellation request by the **15th** of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

PLAN HIGHLIGHTS

The dental services covered by this insurance are divided into four main categories shown below. This dental summary of benefits is intended to describe only a general outline of the plan of benefits and does not represent the actual terms and conditions of the Policy.

Dental Plan $1,000 maximum annual benefit per person.

SERVICE	*DEDUCTIBLE*	*COINSURANCE*	*WAITING PERIOD*
Preventive and diagnostic treatment (cleaning & x-rays, every 6 months)	*$10.00**	*100%*	*None*
Basic treatment (fillings, oral surgery, periodonics)	*$50 per person***	*80%*	*6 months*
Major treatment (Crowns, bridges, dentures)	*$50 per person***	*50%*	*1 year*
*Orthodontic treatment ******	*None*	*50%*	*2 years*

* *The deductible for Preventive and Diagnostic Treatment is the amount payable by you or your insured dependent each time you visit a dentist's office.*

* * *The deductible includes total expenditures per person for all basic and major treatment combined.*

*** *Orthodontic treatment is available to eligible dependent children; lifetime maximum benefit is $1,500.*

All coverage is subject to reasonable and customary fee guidelines. ReliaStar uses the 80th percentile of fee data from an independent contractor to determine reasonable and customary fees. Dental charges in excess of the reasonable and customary fees are the participant's responsibility.

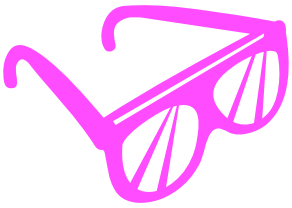
PREMIUM INFORMATION

You can purchase dental coverage for yourself and your eligible dependents by choosing from any one of the following coverage categories. Premium rates are effective until December 31, 2006.

	Monthly Premium
Retiree only	$ 33.54
Retiree & spouse	$ 64.58
Retiree & child(ren)	$ 75.22
Family (retiree, spouse & children)	$106.30

COVERAGE QUESTIONS?

Please contact ReliaStar, plan administrator, at **1-800-965-4148.**



RETIREE VISION COVERAGE

The group vision plan is available to retired employees that are receiving a retirement benefit from North Dakota Public Employees Retirement System (NDPERS), TIAA-CREF, ND Teachers Fund For Retirement (TFFR), or the Job Service Retirement Plan. This coverage allows you to choose your own eye care professional. The plan highlights and the current premium rates are included for your information.

Retirees may elect to enroll in the vision plan within 31 days of a "qualifying event." The "qualifying events" are as follows:

ELIGIBILITY

To be eligible to join the Vision Plan:

A member must be receiving a "retirement allowance" from:

- North Dakota Public Employees Retirement System (NDPERS)
  - Defined Benefit Plan
  - Defined Contribution Plan
- North Dakota Highway Patrol Retirement System (NDHPRS)
- Job Service Retirement Plan
- Teacher's Fund for Retirement (TFFR)
- Teachers Insurance and Annuity Association College Retirement Equities Fund (TIAA-CREF) (North Dakota University System only)

A surviving spouse must be:

- Receiving a beneficiary benefit from the aforementioned retirement plans, or
- On the Vision Plan as a covered dependent at the time of member's death and there is no lapse in coverage.

A non-spouse beneficiary is not eligible to continue on the group vision plan.

ENROLLMENT

A member or surviving spouse must apply within 31 days from any one of the following "qualifying events":

1. Date of retirement, defined as either:

   - The last day of active employment if member does not defer his/her retirement benefit or take a lump-sum refund of his/her retirement account, or
   - Date of first retirement check if member deferred his/her retirement benefit.

2. Members 65th birthday or eligibility for Medicare;

3. Members spouse 65th birthday or eligibility for Medicare;

4. The loss of coverage in a dental plan sponsored or provided by member's employer or member's spouse's employer, if covered through spouse's employer group plan. This includes loss of coverage due to the death of, or divorce from a spouse as well as completion of COBRA continuation coverage.

5. Marriage

6. Birth, adoption, or appointment of children for legal guardianship.

If a member or surviving spouse does not enroll within 31 days of any one of the above qualifying events, he/she will have forfeited his/her rights to enroll in the Plan in the future.

COVERAGE EFFECTIVE DATE

If a member is enrolled in the Vision Plan as an active employee, coverage will become effective on the first of the month following the final date of coverage provided by his/her employer. If a member was not enrolled in the Vision Plan at the time of application, coverage will become effective on the first day of the month following one of the "qualifying events" listed above.

PREMIUM PAYMENT POLICY

Retirement Plan	Payment Method
NDPERS Defined Benefit[1]	Benefit Check Bank Account
NDPERS Defined Contribution[3]	Bank Account
NDHPRS[1]	Benefit Check Bank Account
Job Service[1]	Benefit Check Bank Account
TFFR[2]	Benefit Check Bank Account
TIAA-CREF[3]	Bank Account
Approved Employer Sponsored[3]	Bank Account

1. If retirement allowance is large enough to deduct the entire monthly premium, the premium will automatically be withheld from the benefit check. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50131. It is the policy of NDPERS that a member's net annuity payment can not be less than $25.00.

2. If TFFR retirement allowance is large enough to deduct the entire monthly premium, an election to have premiums withheld from a benefit check must be made. Complete an Payroll Deduction Authorization (313) SFN 19182. If retirement allowance is not large enough, premium must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50131. It is the policy of NDPERS that a member's net annuity payment can not be less than $25.00.

3. If retirement allowance is issued from the NDPERS Defined Contribution plan, TIAA-CREF, or a Board approved employer sponsored retirement plan, premiums must be withheld from a bank account. Complete an Authorization for Automatic Premium Deduction SFN 50131. It is the policy of NDPERS that a member's net annuity payment can not be less than $25.00.

CANCELLATION POLICY

To cancel NDPERS vision coverage, a written request must be submitted. The request must provide the contract holder's name, social security number and effective date. NDPERS must receive a cancellation request by the **15th** of the month prior to the effective date. Cancellations will only be done at the end of the month. We cannot cancel a policy for a partial month or do a retroactive cancellation of a policy.

Plan Highlights

Covered vision services fall into four main categories as shown below:

Service	Deductible*	Benefit Amount**	Waiting Period (Late Entrant)
Vision Examination (Once every 12 months)	None	$35	None
Frames (Once every 12 months)	$40	$40	12 months
Lenses (Per Pair, Once every 12 months)	None		12 months
Single Vision		$35	
Bifocal		$50	
Trifocal		$65	
No Line Bifocal or Progressive		$70	
Lenticular (cataract surgery)		$70	
Contact Lenses (Once every 12 months)	$40	$75	12 months

*Lifetime Deductible per person-applies to frames and contact lenses only.
**The benefit paid will be the lesser of the actual amount charged or the benefit amount shown above. You will be responsible for any cost over the plan benefit amounts. Benefits will be paid for glasses or contact lenses but not both each 12 months.

PREMIUM INFORMATION

You can purchase vision coverage for yourself and your eligible dependents by choosing from any one of the following coverage categories. Premium rates are effective until December 31, 2006.

	Monthly Premium
Retiree only	$ 5.16
Retiree & spouse	$10.32
Retiree & child(ren)	$ 9.40
Family (retiree, spouse & children)	$14.56

COVERAGE QUESTIONS?

Please contact Ameritas, plan administrator, at **1-800-255-4931.**

RETIREE LONG TERM CARE COVERAGE

NEW COVERAGE

The Long Term Care plan is available to retired employees that are receiving a retirement benefit from North Dakota Public Employees Retirement System (NDPERS), TIAA-CREF, ND Teachers Fund For Retirement (TFFR), or the Job Service Retirement Plan.

You and/or your spouse may enroll at any time and must be medically underwritten. Coverage is effective the first day of the month following approval by UNUM. The Long-Term Care enrollment kit includes a description of the benefits and the premium information.

Long Term Care (LTC) insurance pays benefits based on your ability to function independently as defined by six Activities of Daily Living (ADLs). The ADLs used to measure your ability to function independently are bathing, dressing, toileting, transferring, continence, and eating. If you lose the functional capacity or require standby assistance to perform any two of the six ADLs, UNUM considers you to have lost the ability. The plan also pays benefits for long-term care needs that result from cognitive impairment that results from advanced age, Alzheimer's disease, or similar forms of irreversible dementia.

The plan offers additional optional features that give you the freedom to design your LTC plan. The "Paid-Up" feature provides protection should you stop paying premiums for any reason. The "Inflation Protection" feature protects your LTC benefit from the impact of inflation. Your premium amount will be based on your age at the time you apply for coverage, the level of coverage you select, and your lifetime maximum benefit amount.

PORTABLE COVERAGE

If you participate in the UNUM Long-Term Care plan, you may elect portable coverage. This means that the same coverage you had under this plan can continue on a direct billing basis.

Any election for portable coverage **MUST** be made within 31 days of the date the group coverage would otherwise end by completing the UNUM's Election for Portable Coverage.

Any premium that applies must be paid directly to Unum by you for any portable coverage to be continued.

Please refer to your "Certificate of Insurance" for details.

COVERAGE QUESTIONS?

Please contact UNUM, plan administrator, at **1-800-227-4165**.

FLEXCOMP

TERMINATION OF EMPLOYMENT

MEDICAL SPENDING REIMBURSEMENT ACCOUNT

If you retire or terminate employment during the Plan Year, you will be offered COBRA continuation coverage through the end of the Plan year on December 31. You will have sixty (60) days from the date the notice of your right to continue coverage is provided by NDPERS to elect continuation coverage, complete the Continuation of Coverage in Medical Spending Account (COBRA) SFN 53512. Unless you select COBRA, your coverage will end on the last day of the month in which you terminate your employment.

If you elect COBRA continuation coverage, the remaining program contribution payments will be charged to you in equal payments through the end of the Plan Year at 102%. Any program contribution payment amount in excess of 100% of the cost of providing coverage shall not be credited to the participant's account but shall be treated as an administrative charge.

If continuation coverage is elected, coverage will be extended to the end of the current Plan Year but may terminate sooner if the premiums described above are not paid within 30 days of their due date which is the 1st of every month.

If participation terminated due to a separation of service and you return to state employment within 30 days in the same Plan Year, your election will be reinstated as it was immediately prior to the separation of service. If you return to state employment after 30 days in the same Plan Year, you can not participate for the remainder of the Plan Year.

DEPENDENT CARE REIMBURSEMENT ACCOUNT

If you terminate employment, your contributions will cease and payroll deductions will stop after the last day of the month in which you terminate. You may continue to file claims for qualifying expenses incurred during the Plan Year until you have been reimbursed the balance in your account at the time of your termination.

The final day for accepting claims for the Plan Year from either your Medical Spending or Dependent Care Reimbursement account for services received while you were a participant is three months after the Plan Year ends on December 31 or March 31.

DEFERRED COMP
TERMINATION NOTICE

Employees who participate in the deferred compensation plan and who upon termination of employment will receive a lump sum payment for accumulated annual leave, sick leave, or back pay may defer these payments to the deferred comp plan. These deferrals are treated as part of the participant's annual deferrals, and are subject to the IRS annual 457 Plan limits in effect for the year in which the deferrals are made. Lump sum deferrals are subject to FICA before deferral.

Employees must elect to defer sick, annual leave and back pay payments while actively employed and in the month prior to the month of termination by completing the "457 Participant Agreement SFN 3803". The regulations do not allow deferrals for severance or buyout pay or bonuses.

Terminating employees may not begin to receive distributions from a deferred compensation account until they have been off the payroll of covered employer for one month. You may elect to begin distribution immediately after you have satisfied the 30 day period, regardless of your age, or you may defer payments to a future date. **There is no IRS 10% penalty or requirement for age 59 ½**.

Once you have begun distribution, you also have the option of suspending distribution or changing the amount of the distribution, so long as the **minimum required distribution at age 70 ½ is distributed**.

You also have the option to do a direct rollover to an eligible 401(a), 401(k), 457(b), 403(b), IRA or another qualified plan that accepts eligible rollover distributions. If you do a direct rollover, taxes are not due until you begin receiving a distribution from your account.

If you elect a lump sum distribution, you will be subject to a 20% Federal income tax withholding requirement. The Provider Company will send you a 1099R statement the year in which you received distribution from your account.

Please consult with your investment Provider representative for assistance in selecting a payment option or if you have any questions regarding your tax liability or withdrawal penalties.

Estimated Benefit Payment Worksheet

FOR MEMBER USE ONLY – DO NOT RETURN TO NDPERS

GROSS PENSION AMOUNT: $ _____

LESS DEDUCTIONS:

HEALTH INSURANCE: $ _____

LIFE INSURANCE: $ _____

DENTAL INSURANCE: $ _____

VISION INSURANCE: $ _____

FEDERAL INCOME TAX: $ _____

ND STATE INCOME TAX: $ _____

NET PENSION AMOUNT: _____

NOTICE OF STATUS OR EMPLOYMENT CHANGE

New Retiree

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53611 (REV. 01-06)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY BY THE AUTHORIZED AGENT

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657

(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A MEMBER INFORMATION

Name (Last, First, Mi)	Social Security Number
Department Name	Department Number

PART B CHANGE OF STATUS NOTICE

Effective Date

☐ Leave of Absence/Leave without Pay

Reason for Leave: _____

Recertification Date: _____ Date of Return: _____

☐ Classification Change:

From			To		
☐Classified State	☐Non-Classified State	☐Non-State	☐Classified State	☐Non-Classified State	☐Non-State
☐Seasonal	☐Elected Official	☐Salaried	☐Seasonal	☐Elected Official	☐Salaried
☐Non-Seasonal	☐Appointed Official	☐Hourly	☐Non-Seasonal	☐Appointed Official	☐Hourly

☐ Reduction in Hours:

☐ _____Hours to _____Hours

☐ Permanent to Temporary/Part-time (Distribute SFN 17627 to employee)

PART C SEPARATION OF EMPLOYMENT

☐ Notice of Retirement ☐ Notice of Long Term Disability ☐ Notice of Death ☐ Notice of Termination

(Do not use this form for Notice of Transfer-Complete a Notice of Transfer Kit)

Has the appropriate "KIT" been provided to employee/surviving spouse? ☐No ☐Yes, Date _____

Last Date of Service with Current Agency	Date of Last Regular Paycheck
Last Month Insurance Premium(s) will be paid by your agency/or this employee (Month & Year) :	Projected Accumulated hours of sick leave to date of separation:
Last retirement transmittal of deduction (Month & Year):	Last retirement transmittal due: (Month, 8th, & Year):

PART D PLAN INFORMATION (Check all the plans the employee is currently participating in)

Group Insurance	Retirement	Other Plans
☐Health Insurance	☐Defined Benefit	☐Deferred Compensation (457/403(b))
☐Single Coverage ☐Family Coverage	☐Defined Contribution	
☐PERS Dental; Current Dental Premium $ _____	☐TIAA-CREF	
☐PERS Vision; Current Vision Premium $ _____	☐TFFR	☐PERS Flex Comp (125)
☐PERS Life Insurance	☐Job Service	
☐PERS Long Term Care	☐Highway Patrol	

PART E AUTHORIZATION OF AUTHORIZED AGENT

I certify that the above information is true and correct.

_____ Authorized Agent Signature

_____ Date of Signature

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

INSTRUCTIONS

Part A Member Information

Enter member's name and social security number
Enter the employer's name and department number

Part B Change of Status Notice

Complete this section if an employee is on a leave of absence or experiences a reduction in hours.

Part C Separation of Employment

Complete this section if an employee is leaving your service due to Long Term Disability, Death, Termination (non-retirement), or Retirement.

Due to varying payroll cycles employers use, NDPERS needs to confirm the last Transmittal of Deduction for Retirement Contributions for retiring members. This is to ensure benefits are paid to a member for the correct time period and not overpaid or underpaid.

Eligible "wages" and "salaries" means the member's earnings in eligible employment under this chapter reported as salary on the member's federal income tax withholding statements plus any salary reduction or salary deferral amounts under 26 U.S.C. 125, 401(k), 403(b), 414(h), or 457. "Salary" does not include fringe benefits such as payments for unused sick leave, personal leave, vacation leave paid in a lump sum, overtime, housing allowances, transportation expenses, early retirement incentive pay, severance pay, medical insurance, workforce safety and insurance benefits, disability insurance premiums or benefits, or salary received by a member in lieu of previously employer-provided fringe benefits under an agreement between the member and participating employer. Bonuses may be considered as salary under this section if reported and annualized pursuant to rules adopted by the board.

If an employee is leaving your service because of a transfer to another participating PERS employer, you must complete a Notice of Transfer Kit. Please always refer to PERS listing of participating employers to determine if an employee is transferring employment.

A PERS "Kit" must be given to the employee or surviving spouse to complete. **A completed kit must accompany the Notice of Status or Employment Change.**

Part D Plan Information

Indicate ALL the plans your employee participates in through your agency.

Part E Authorization of Authorized Agent

Your agency's designated PERS authorized agent must sign and date this form.

APPLICATION FOR DISABILITY RETIREMENT

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 18000 (Rev. 07-2005)

New Retiree

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657
Bismarck • ND • 58502-3920

PART A EMPLOYEE INFORMATION

Name (Last, First, Mi)				Social Security Number
Date of Birth	Age	Sex ☐ Male ☐ Female	Marital Status ☐ Married ☐ Single	Home Telephone Number
Mailing Address	City	State	Zip Code + 4	

PART B OTHER BENEFITS

Are you eligible to receive the following benefits? Please check and complete the appropriate boxes.

YES	NO	BENEFITS	Date Benefits Began	Date Benefits Terminate	Amount	Paid Weekly	Paid Monthly
		Workers Compensation Benefits?					
		Unemployment Compensation Disability?					
		Sick Pay?					
		Social Security Benefits?					
		Retirement Income (Current or Past Employers?)					

Has Social Security Been Applied For? ☐ Yes ☐ No | Has Worker's Compensation Benefits Been Applied For? ☐ Yes ☐ No

PART C APPLICATION FOR DISABILITY BENEFITS

SECTION 1 RETIREMENT PAYMENT OPTION (Check One)

☐ Single Life / Normal Retirement
☐ 50% Joint Survivor/Life ☐ 100% Joint Survivor/Life
☐ 20 Year Term Certain/Life ☐ 10 Year Term Certain/Life

SECTION 2 RETIREE HEALTH INSURANCE CREDIT OPTION (Check One)

☐ I elect the standard retiree health credit option specific to the retirement payment option selected in section 1.
☐ If married and selected the Single Life, 20 or 10 Year Term Certain; I elect the following alternate actuarially reduced retiree health credit option.

(Check One): ☐ 50% Joint Survivor Life
☐ 100% Joint Survivor Life

PART D SICKNESS OR INJURY DATA

Date of Sickness or Injury	Date You First Noticed Symptoms	Date You First Saw a Physician For This Sickness or Injury
Cause of Disability		
Name of Treating Physician (If more than one, list on separate sheet of paper.)		

Address	City	State	Zip Code + 4
If Hospitalized For Sickness or Injury, Give Name of Hospital	Date Admitted	Date Released	

Are You Bed Confined? ☐ Yes ☐ No	Are You House Confined? ☐ Yes ☐ No	Have You Ever Had The Same Kind of Sickness or Injury Before? ☐ No ☐ Yes, Specify date and physician's name and address below.	
Date of Accident?	Time of Accident?	Was Accident Work Related?	Where Did The Accident Occur?
Date You Were First Able To Leave Home For Any Purpose?		Date You Were First Able To Do Any Part Of Your Work, Supervisory or Otherwise?	

CONTINUED ON BACK

PART E EDUCATION

Last Year Completed	Name of School	
Last Year in School	Degree/Certificate	Additional Training
Attitude Towards School ☐Like ☐Dislike	Favorable Courses	

PART F MILITARY SERVICE

Branch	Date From: To:	Discharge ☐Honorable ☐General ☐Other (Specify)
Duties/Responsibilities		
Rank	Special Training	
Service Connected Disabilities		

PART G WORK HISTORY (List Most Recent First)

Employer		Supervisor
Job Title(s)		
Dates: From: To:	Salary	Duties
Union		Representative
Employer		Supervisor
Job Title(s)		
Dates: From: To:	Salary	Duties
Union		Representative
Employer		Supervisor
Job Title(s)		
Dates: From: To:	Salary	Duties
Union		Representative

PART H MEMBER AUTHORIZATION

Release of Information:

To all physicians and other medical professionals, hospitals, and other medical-care, institutions, and to insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators:

You are authorized to provide MidDakota Clinic and any benefit plan administrators, consumer reporting agencies, attorneys, and independent claim administrators acting on MidDakota Clinic's behalf with information concerning medical care, advice, treatment, or supplies provided the patient, including information relating to mental illness and any employment related information regarding the patient. This information will be used for the purpose of evaluating and administrating claims for benefits.

In understand that the duration of the authorization is for the term of coverage of the policy or contract under which a claim for health benefits has been submitted. If this authorization is given in connection with a claim for disability or life insurance benefits, I understand that it is valid for the duration of the claim.

I understand that I have a right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I elect to receive the retirement benefits and health credit as indicated in PART C. I understand I must submit a photocopy of my birth certificate. (If married, also submit a photocopy of spouse's birth certificate & marriage certificate)

_____ _____

Member's Signature Date

DISABILITY RETIREMENT OCCUPATIONAL DEMANDS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 54398 (Rev. 03/2006)

New Retiree

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

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This form should be completed in an objective manner by the employee's immediate supervisor or by another individual possessing comprehensive knowledge regarding the occupational demands of the employee's job. This form is then submitted to the treating physician for review in completing the Attending Physician's Statement. Both forms must be returned to NDPERS.

PART A EMPLOYEE INFORMATION

Name (Last, First, Mi)	Social Security Number

Job Description (Please attach a copy of the employee's job description)	Department Name

PART B PHYSICAL DEMANDS

Indicate the number of times per day for:	Lifting*	Carrying**
1-5 pounds		
6-10 pounds		
11-25 pounds		
26-50 pounds		
51-100 pounds		
100 pounds or more		

Indicate the percent of day each activity is performed:			
Sitting	%	Outside work	%
Standing	%	Working with others	%
Walking	%	Working around others	%
Inside work	%	Working alone	%

Additional Comments:

*Includes pushing and pulling effort while stationary
**Includes pushing and pulling effort while walking

What are the average hours per day worked on this job?	What are the average days per week worked on this job?

Is overtime required?
☐No ☐Yes-How many hours/day: How many days/week:

Indicate extent of performance of each of the following:

	Often	Significant	Seldom	Never
Ascending and descending stairs	☐	☐	☐	☐
Ascending and descending ladders	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Reaching above shoulders	☐	☐	☐	☐
Reaching below shoulders	☐	☐	☐	☐

Occupational Requirements:

☐	Far Vision	☐	Talking
☐	Near Vision	☐	Depth Perception
☐	Hearing	☐	Other (Explain)_____

Did the employer request that the agency provide accommodations to assist employee in meeting the physical demands of the employee's job? ☐No ☐Yes, Please explain the type of accommodations provided:

_____

_____

_____

PLEASE COMPLETE BACK OF FORM

PART C EMOTIONAL STRESS

Does the employee have to answer to customer complaints?
☐ Often
☐ Sometimes
☐ Not at all

The employee is expected to perform the job at a normal, average pace....
☐ Most of the time
☐ Some of the time
☐ Occasionally:_____% of the time

The employee is expected to perform the job at a rapid pace.....
☐ Most of the time
☐ Some of the time
☐ Occasionally:_____% of the time

Must the employee depend upon the assistance of others in order to accomplish daily tasks? ☐ No ☐ Yes, how often?
☐ Most of the time
☐ Occasionally:_____% of the time

How close must the employee work with fellow workers?
☐ Very closely
☐ Significant contact
☐ Minor contact

How many employees does this employee supervise? _____

Is employee routinely subject to close supervision? ☐ No ☐ Yes

Does the employee's job consist primarily of prescheduled activities, or of tasks that arise randomly during the day?
☐ Primarily prescheduled
☐ Primarily random

What percentage of the employee's time is spent meeting deadlines set by other? _____%

How much responsibility does the employee have for the overall performance of his/her particular department:
☐ 100 percent
☐ Great deal
☐ Significant
☐ Minor

In your opinion, what degree of emotional stress is this employee subject to during the performance of his/her job?
☐ Great
☐ Significant
☐ Some
☐ Very Little

The above questions, both involving physical demands and emotional stress, require primarily objective answers. Your subjective and/or supplementary comments would also be appreciated.

_____

_____

_____

PART D CERTIFICATION

Completed by:	Title:	Daytime Telephone Number:
Address:		
Signature:		Date:

New Retiree

DISABILITY RETIREMENT ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 54399 (Rev. 07-2005)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

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Under the Long Term Disability Plan, an employee is eligible to receive benefits if medically disabled from performing the duties of any occupation the employee may be qualified for based on individual training, education, experience, and past job history.

The patient is responsible for the completion of this form without expense to the employer.

PART A EMPLOYEE INFORMATION

Name (Last, First, Mi)	Social Security Number

PART B PHYSICIAN'S STATEMENT

In order to determine benefit eligibility and rehabilitation, answer the following questions:

HISTORY

Date symptoms first appeared or accident happened?	Date patient ceased work because of disability	Has patient ever had same or similar condition?
/ /	/ /	☐Yes ☐No

PRESENT CONDITION

Subjective Symptoms	Objective Findings
Diagnosis	**Prognosis**

TREATMENT

Date of First Visit	Date of Last Visit	Frequency of Visits	Date Patient was Last Examined
/ /	/ /		/ /

EXTENT OF DISABILITY

1. Is the employee totally disabled from any occupation as defined above? ☐No ☐Yes

2. If the disability is not considered total and permanent, do you anticipate a release to their regular occupation?
☐No ☐Yes- When?

3. If you answered "no", do you anticipate a release to a less physically and/or emotionally demanding occupation?
☐No ☐Yes-When?
If yes, please complete the physical capacities evaluation on the back side of this form, this will provide us with the physical limitations placed on the employee.

4. If the employee is totally disabled as defined above, would you feel it appropriate to consider VOCATIONAL and/or MEDICAL REHABILITATION? ☐No ☐Yes
If yes, please complete the physical capacities evaluation on the back side of this form, this will provide us with the physical limitations placed on the employee.

MENTAL CONDITION

1. Is the patient competent to endorse checks and direct the use of the proceeds thereof? ☐No ☐Yes

Complete the appropriate section below if disability is due to CARDIAC CONDITION or VISUAL IMPAIRMENT.

CARDIAC

Functional Capacity (American Heart Association):	Blood Pressure
☐Class 1 (No limitation) ☐Class 3 (Marked limitation) ☐Class 2 (Slight limitation) ☐Class 4 (Complete limitation)	

VISUAL IMPAIRMENT

		O.D.	O.S.	Month	Day	Year
What was vision at last observation?	With Glasses					
	Without Glasses					

PLEASE COMPLETE BACK OF FORM

PART C PHYSICAL CAPACITIES EVALUATION

IMPORTANT: Please complete the following items based on your clinical evaluation, other testing results, patient discussions, and/or job analysis. Any item that you do not believe you can answer should be marked N/A (not available).

In an eight hour workday, claimant can: (Check time for each activity)

	1 hour	2 hours	3 hours	4 hours	5 hours	6 hours	7 hours	8 hours
Sit								
Stand								
Walk								

If any of the above three require alternating positions, please indicate frequency:

_____

_____

In terms of an eight hour workday, "occasionally" equals 0-33; "frequently" equals 34-36, "continuously" equals 67-100 percent.

Claimant can lift…	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐

Claimant can carry…	Never	Occasionally	Frequently	Continuously
Up to 10 pounds	☐	☐	☐	☐
11-20 pounds	☐	☐	☐	☐
21-50 pounds	☐	☐	☐	☐
51-100 pounds	☐	☐	☐	☐

Claimant can use hands for repetitive action such as:

	Simple Grasping		Pushing and Pulling		Fine Manipulation	
Right	☐Yes	☐No	☐Yes	☐No	☐Yes	☐No
Left	☐Yes	☐No	☐Yes	☐No	☐Yes	☐No

Claimant can use feet for repetitive movements as in operating foot control:

Right	☐Yes	☐No
Left	☐Yes	☐No
Both	☐Yes	☐No

Claimant is able to:	Not at all	Occasionally	Frequently	Continuously
Bend	☐	☐	☐	☐
Squat	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐

Restrictions of activities:	None	Mild	Moderate	Total
Unprotected heights	☐	☐	☐	☐
Being around marked changes in temperature and humidity	☐	☐	☐	☐
Driving automobile equipment	☐	☐	☐	☐
Exposure to dust, fumes, and gases	☐	☐	☐	☐

Remarks on Above, or other Functional Limitations:

PART D CERTIFICATION

Name (print)	Degree	Daytime Telephone Number

Mailing Address (print)	City (print)	State	Zip Code + 4

_____ _____

Signature of Attending Physician Date

DESIGNATION OF BENEFICIARY FOR THE GROUP RETIREMENT PLAN

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 2560 (Rev. 01-06)

New Retiree

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

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PART A MEMBER INFORMATION

Name (Last, First, Mi)	☐Married ☐Single ☐Divorced ☐ Widowed	Social Security Number
Spouse Name (Last, First, Mi)	Spouse Gender ☐Male ☐Female	Social Security Number

PART B PRIMARY BENEFICIARY (IES) – Complete all sections

Name	Relationship	Social Security Number	Birth Date	% Share	Address
			Total must equal	**100%**	

PART C CONTINGENT/SECONDARY BENEFICIARY(IES)

Name	Relationship	Social Security Number	Birth Date	% Share	Address
			Total must equal	**100%**	

PART D MEMBER AUTHORIZATION

I understand that this election revokes any previous retirement account beneficiary designations. I understand that, if married, any initiation of dissolution or annulment of my marriage may void this designation. I have read and understand the terms and conditions listed on page 2 of this designation. I hereby certify that the information provided on this form is true and correct to the best of my knowledge.

_____ _____

Member Signature Date of Signature

PART E SPOUSE AUTHORIZATION

IF YOU ARE MARRIED AND DESIGNATE A BENEFICIARY OTHER THAN OR IN ADDITION TO YOUR SPOUSE, YOUR SPOUSE MUST COMPLETE THIS SECTION

If a member dies while actively employed before completing three years of service, a lump sum payment of his/her retirement account will be paid to the listed beneficiary (ies).

If a member with three or more years of credited service is married, North Dakota law requires the spouse's consent before benefits can be paid other than to the member's spouse. (NDCC 30.1-05-02). If spouse's consent is given, please be advised, that if your primary beneficiary election is someone in addition to or in lieu of your spouse, there is no monthly pre-retirement death benefit provision.

I consent to the above retirement beneficiary (ies) designated by the above named NDPERS member.

_____ _____

Spouse Signature Date of Signature

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

DESIGNATION OF BENEFICIARY FOR THE GROUP RETIREMENT PLAN
SFN 2560 (Rev. 01-06)

PROVISIONS FOR ALL BENEFITS

1. This "Designation of Beneficiary" is for the group Retirement Plan only. To designate beneficiary (ies) for the group Life Insurance Plan, please complete a “Life Designation of Beneficiary Change SFN 53855”.

2. **EFFECTIVE WHEN FILED:** This designation will be effective when properly executed and received in the NDPERS office.

3. **SUBJECT TO LAWS AND REGULATIONS:** This designation is subject to the governing statutes and to rules and regulations established by the Retirement Board of the North Dakota Public Employees Retirement System. The acceptance o the designation by NDPERS does not establish that a survivor benefit will be payable. Whether or not a benefit is payable and the amount thereof will be determined at the time of death under laws and regulations then applicable.

4. **WHO IS ELIGIBLE TO BE A BENEFICIARY:** Any person, whether or not a relative, or a church or charity may be designated as a primary or contingent beneficiary. A member may also designate his or her estate as beneficiary and the benefits will be distributed according to his or her testamentary will or according to the state laws for interstate distribution. A creditor of a member (such as a bank, credit union, loan company, etc.) may not be named a beneficiary as a means of providing security for a debt. (N.D.C.C. 28-22-19)

5. **TWO OR MORE BENEFICIARIES:** If more than one person in a class (primary or contingent beneficiary) is named, they will share equally in the benefit unless specific shares are designated. If specific shares are designated, they must equal 100 percent. The benefit will be distributed as directed by the designation. If a named beneficiary does not survive, the share will be distributed among any surviving beneficiaries in proportion to the shares designated.

   If shares are not designated, NDPERS will distribute benefits equally to the named beneficiary (ies). As this distribution may not reflect the member’s preference, we recommend the member be sure to designate the percent of share for each listed beneficiary.

NOTE: Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established.

7. If there are no surviving beneficiaries, all benefits will be paid to your estate.

8. A **certified** copy of the death certificate must be sent to NDPERS to process a claim.

PROVISIONS FOR RETIREMENT BENEFITS ONLY

1. DEATH OF ACTIVELY EMPLOYED MEMBER:

   A. If a member dies while actively employed before completing three years of service, a lump sum payment of his/her retirement account will be paid to whoever is the listed beneficiary(ies).

   B. If a member dies after completing three years of service, his/her retirement account will be distributed pursuant to N.D.C.C. 54-52-17(6) and N.D.C.C. 39-03.1-11(6).

2. **DEATH OF RETIREE:** Benefits will be paid to the named beneficiary based upon the option selected by the member at retirement. If there are no surviving beneficiaries, any remaining cash value will be paid to your estate.

3. **DEATH OF SURVIVING SPOUSE:** A lump sum payment of any remaining cash value will be paid to the spouse's named beneficiary. If there are no surviving beneficiaries, any remaining cash will be paid to the spouse's estate.

North Dakota Public Employees Retirement System
400 E Broadway, Suite 504
P.O. Box 1657
Bismarck, North Dakota 58502-1657
Telephone: (701) 328-3900
Toll Free: 1-800-803-7377

New Retiree

AUTHORIZATION FOR DIRECT DEPOSIT FOR ANNUITY PAYMENTS

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 18379 (Rev. 03/04)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Section 3402. The individual's social security number will be used for tax reporting and as an identification number.

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PART A ANNUITANT / PAYEE (Must Be Completed By Member)

Annuitant/Payee	Social Security Number

I authorize the North Dakota Public Employees Retirement System (NDPERS) and the financial institution named on this form to initiate electronic fund transfer (EFT) of my monthly retirement benefit to my account indicated below. I consent to the financial institution sharing my customer information with NDPERS for the purpose of completing the EFT arrangement.

☐ Checking Account Number: _____

☐ Savings Account Number: _____

This authorization will remain in effect until I notify NDPERS in writing to cancel it in such time as to afford NDPERS a reasonable opportunity to act on it.

I agree to the terms listed on this authorization.

_____ _____
Signature of Annuitant/Payee Date

PART B FINANCIAL INSTITUTION (Must Be Completed By Institution)

Name of Financial Institution

Mailing Address	City	State	Zip Code

Payee's Account Number	Type of Account
	☐ Checking ☐ Savings

Routing Number (9 Digits)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

We, the financial institution named on this form, agree to receive and deposit sums for the payee. We agree to notify NDPERS upon becoming aware of the death of the payee.

The payee has the right to cancel this authorization, and we reserve the right to cancel this agreement by written notice to the payee. NDPERS retains the right to reclaim all amounts paid in error to the member or authorized financial institution.

_____ _____
Signature of Financial Institution Representative Date of Signature

Financial Institution Representative (Please Print)	Title	Telephone Number

PART C NDPERS USE ONLY

Effective Date:

ORIGINAL TO NDPERS – PLEASE MAKE A PHOTOCOPY FOR YOUR RECORDS

INSTRUCTIONS AND CONDITIONS

IMPORTANT NOTICE - This form is to be used only for North Dakota Public Employees Retirement System Benefit Payments.

If you wish your monthly benefit payments sent to your financial organization for deposit into your savings or checking account, both you and the financial organization must complete this form to authorize this action. The North Dakota Public Employees Retirement System will forward these payments to the point you authorize. The financial organization may be any bank, savings bank, savings and loan association or similar institution, or Federal or State chartered credit union.

THIS FORM ONLY AUTHORIZES DEPOSITS INTO YOUR ACCOUNT.
IT DOES NOT AUTHORIZE WITHDRAWALS FROM YOUR ACCOUNT.

PART A ANNUITANT / PAYEE SECTION

LINE 1 – Print or type the full name and social security number of the person to whom the payment is made.

LINE 2 – Check the type of account and print account number for the account in which this payment is to be deposited.

LINE 3 - Sign and date the form.

PART B FINANCIAL INSTITUTION SECTION

After completing the top portion of this form, the form should be delivered or sent to the designated financial institution. Upon completion, you and the financial institution should retain a photocopy for your records and the original is to be sent to:

North Dakota Public Employees Retirement System
P.O. Box 1657
Bismarck, ND 58502-1657
Telephone: (701) 328-3900

CANCELLATION INSTRUCTIONS

When entered in your record with the North Dakota Public Employees Retirement System, this authorization will remain in effect until canceled by written notice by you to the North Dakota Public Employees Retirement System, or in the event of your death. The financial organization should also be notified if you cancel this agreement.

The financial organization may cancel their agreement by providing you a written notice 30 days in advance of the cancellation date. You must advise the North Dakota Public Employees Retirement System if this authorization is canceled. The financial organization cannot cancel this authorization by advice to the North Dakota Public Employees Retirement System.

FINANCIAL INSTITUTION

Immediate credit will be given the first working day of each month through your correspondent bank account at the Bank of North Dakota.

FORM W-4P (SUBSTITUTE) TAX WITHHOLDING CERTIFICATE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 51506 (Rev. 01-06)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

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PART A MEMBER INFORMATION

Name (Last, First, Middle)		Social Security Number	
Mailing Address	City	State	Zip Code +4
Effective Date _____/_____/_____		Daytime Telephone Number	

Please read the instructions on the reverse side of this form and complete the following applicable line(s):

PART B FEDERAL INCOME TAX WITHHOLDING

1. I elect NOT to have federal income tax withheld from each periodic pension payment (Do not complete lines 2 or 3.) ……. ☐

2. I want federal income tax withheld from each periodic pension payment which is figured **by using the number of allowances and marital status** shown below: (You may also designate an additional dollar amount on line 3.)

   Step 1: Check marital status:
   ☐Single ☐Married ☐Married, but withholding at the higher Single rate

   Step 2: Enter number of allowances → _____

3. I want the following additional amount withheld from each periodic pension payment.
   (You cannot enter an amount here unless you complete line 2.) ..... $ _____

PART C NORTH DAKOTA STATE INCOME TAX WITHHOLDING

1a. I elect NOT to have North Dakota state income tax withheld from each periodic pension payment.
(Do not complete line 2a.) .....…… ☐

2a. I want North Dakota State income tax withheld from each periodic pension payment.
(Figured as 21% of federal withholding)..... ☐

PART D MEMBER AUTHORIZATION

Member's Signature	Date of Signature

This form is available in an IRS format upon request.

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

FORM W-4P (SUBSTITUTE) TAX WITHHOLDING CERTIFICATE
SFN 51506 (Rev. 01-06)

TAX WITHHOLDING INFORMATION AND INSTRUCTIONS

Your benefits from NDPERS are subject to federal and state income tax withholding. Use Form W-4P (Substitute) to inform NDPERS of your income tax withholding election. The amount withheld will automatically change as the federal tax rates are adjusted each year.

Once you make an election, it will remain in effect until you change or revoke it. You must file a new Form W-4P to change your filing status and/or the number of exemptions used in determining the amount being withheld from your pension benefit.

If you choose not to have tax withheld or do not have enough tax withheld, you may have to make estimated tax payments to the Internal Revenue Service (IRS). You may be subject to penalties if your payments of estimated tax and withholding are not sufficient.

If you do not complete Form W-4P, NDPERS is required to withhold federal income tax as though you are married with three (3) withholding allowances. We are not required to withhold North Dakota state income tax.

Federal Income Tax Withholding

1. You can elect not to have income tax withheld by checking the box on line 1 of Form W-4P.

2. To have federal income tax withheld complete line 2 of Form W-4P. For federal income tax purposes, the amount of withholding is based on the marital status and the number of allowances (including zero) you identify on this form.

3. You can also have an additional amount withheld from your NDPERS pension payment by completing line 2 of Form W-4P and writing in an additional amount on line 3 of this form.

North Dakota Income Tax Withholding

For North Dakota residents, your NDPERS pension benefit is subject to state income taxes. If you are not a North Dakota resident, the benefits are taxable in the state in which you live.

1a. You can elect not to have ND state income tax withheld by checking the box on line 1a of Form W-4P.

2a. To have ND state income tax withheld (21% of federal withholding), check the box on line 2a of Form W-4P.

Personal income tax questions should be directed to your tax advisor, accountant, or the Internal Revenue Service Center.

RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53799 (Rev. 01-06)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number

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PART A MEMBER INFORMATION

Name (Last, First, MI)	Social Security Number

PART B NDPERS GROUP HEALTH INSURANCE

Do you wish to continue your current coverage in the NDPERS Group Health Insurance Plan? ☐ Yes ☐ No

If Yes at ☐ Current Level of Coverage OR

☐ Reduced Level of Coverage (Self Only) (**SFN 16277 MUST accompany this form**)

Employees terminating employment, or otherwise losing eligibility, may continue their NDPERS Group Health Coverage at their own expense for a maximum of 18 months subject to the following:

1) You must be a member of the plan at time of loss of eligibility.
2) Your spouse or any other dependent(s) applying for this continuation coverage must be a member of the plan at time of loss of eligibility.
3) You must complete and submit this election form to NDPERS within 60 days from your last date of coverage.

If you do not choose continuation coverage, your group health coverage will end on the last day of the month for which premiums were paid.

PART C PAYMENT METHOD & MEMBER AUTHORIZATION

DO NOT SEND MONEY WITH THIS FORM. If a payment method is not elected, you will be billed for the premium due. NDPERS bills the last week of each month for the following month's coverage. Your payment is due the 15th of the month. Failure to remit your premium by the due date will result in loss of health coverage.

RETIREMENT GROUP	PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE →	☐ Deduct from pension check ☐ Withhold from bank account (Complete SFN 50134)
☐ TIAA-CREF ☐ NDPERS DEFINED CONTRIBUTION → ☐ EX-LEGISLATOR	☐ Withhold from bank account (Complete SFN 50134)

I have read this application in its entirety **(including the back page)** and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any benefit plans insured based on this application.

_____ _____

Signature of Member Date

PART D NDPERS USE ONLY

Group Number	Month the last health insurance premium will be paid:	Effective date of coverage:

ORIGINAL TO NDPERS – PLEASE MAKE A PHOTOCOPY FOR YOUR

RETIREE CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE (COBRA)

On July 1, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end.

If you are the spouse of an employee covered by the employer’s group health plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under the group plan for any of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse’s employment (for the reasons other than gross misconduct) or reduction in your spouse’s hours of employment with the employer.
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to (that is, covered by) Medicare.

In the case of a dependent child of an employee covered by the employer’s group health plan, he or she has the right to continuation coverage if group health coverage under the group health plan is lost for any of the following reasons:

1. The death of the employee;
2. A termination of the employee’s employment (for reasons other then a gross misconduct) or reduction in the employee’s hours of employment with the employer;
3. The employee’s divorce or legal separation;
4. The employee becomes entitled to (that is, covered by) Medicare;
5. The dependent child ceases to be a “dependent child” under the group health plan.

Under the law, the employee or a family member has the responsibility to inform NDPERS of a divorce, legal separation or a child losing dependent status under the group health plan within 60 days of the date of the event. The employer with whom you have your NDPERS group health benefit plan has the responsibility to notify NDPERS of an employee’s death, termination, and reduction in hours of employment or Medicare entitlement.

When NDPERS is notified that one of these events has happened, NDPERS will in turn notify you that you have the right to choose continuation coverage. Under the law you have at least 60 days from the date you would lose coverage because of one of the events described above to inform NDPERS that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group health insurance coverage will end. Not choosing continuation coverage may cause a break in your continued coverage and such break of more then sixty-three days may cause loss in coverage portability.

If you choose continuation of coverage, NDPERS is required to give you coverage, which, as of the time coverage is being provided is identical to the coverage provided under the group health plan to similarly situated employees or family members.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18 months may extend to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security disability purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, you must notify NDPERS of the determination within 60-days or before the end of the original 18-month period. The affected individual must also notify NDPERS within 30 days of any final determination that the individual is no longer disabled.

However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The employer no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become entitled to (that is, covered by) Medicare; or
4. You extend coverage for up to 29 months due to disability and there has been a final determination that you are no longer disabled.

RETIREE GROUP HEALTH INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 16277 (Rev.12-05)

New Retiree

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

PART A MEMBER INFORMATION

Member Name (Last, First, Mi)		Social Security Number	
☐ Single ☐ Married	Date of Retirement	Date of Birth	Sex
Spouse Name (Last, First, Mi)		Social Security Number	Date of Birth
Address		City / State	Zip Code + 4

PART B TYPE OF COVERAGE REQUESTED

☐ I **DO NOT** want health insurance at this time ☐ Single Coverage = myself only

☐ Family Coverage = myself and spouse **OR** myself and eligible children **OR** myself, spouse and eligible children.

Please provide information below on yourself, for family coverage, provide information for your spouse and all current dependents.

Last Name First Name	Date of Birth	Sex	Relation	Medicare Part A*	Medicare Part B*	Effective Date
(Self)				☐ YES ☐ NO	☐ YES ☐ NO	
(Spouse)				☐ YES ☐ NO	☐ YES ☐ NO	
(Dependent)				☐ YES ☐ NO	☐ YES ☐ NO	
(Dependent)				☐ YES ☐ NO	☐ YES ☐ NO	
(Dependent)				☐ YES ☐ NO	☐ YES ☐ NO	

***If you checked YES, you MUST submit a photocopy of the applicable Medicare ID card/s and complete the MedicareBlue Rx Prescription Drug Plan Group Enrollment Form.**

In order to continue or obtain coverage under the Dakota Plan or Dakota Retiree Plan, any Medicare Eligible member MUST carry both Parts A & B of Medicare.

PART C PAYMENT METHOD & MEMBER AUTHORIZATION

RETIREMENT GROUP

☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE

☐ TIAA-CREF ☐ NDPERS DEFINED CONTRIBUTION

☐ EX-LEGISLATOR ☐ Alternate Retirement System

PAYMENT OPTION – MUST SELECT ONE

☐ Deduct from pension check

☐ Withhold from bank account (Complete SFN 50134)

☐ Withhold from bank account (Complete SFN 50134)

I authorize the Social Security Administration to furnish Blue Cross Blue Shield of North Dakota with medical or other information acquired under the Title XVIII Program (MEDICARE) during the periods my contracts are in force. I authorize BCBS of North Dakota, or its agent to receive medical information from physicians, hospitals, and other health care providers in order to assure appropriateness of claims payment.

I read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any Benefit Plans insured based on this application.

_____ _____

Signature of Applicant Date Signed

PART D NDPERS USE ONLY

Group Number	Effective date of coverage:	Effective date of change:

☐ Retirement ☐ New Coverage ☐ Medicare Update

☐ Disability ☐ Surviving Spouse ☐ COBRA Ending

☐ Transfer from NDPERS Contract No._____

Change in Dependents

☐ Add Dependent(s)

☐ Remove Dependent(s)

Change in Marital Status

☐ Married ☐ Separated

☐ Divorced ☐ Widowed

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

Please refer to the "Dakota Plan & Dakota Retiree Plan" sheets.

Part A Member Information

Enter your name, date of retirement, marital status, social security number, date of birth, and sex.

Enter your spouse's name, social security number, date of birth, and sex.

Enter your mailing address and day time telephone number.

Part B Type of Coverage Requested

Check the appropriate level of coverage.

If you do not want health coverage, mark the appropriate box and skip to "Signature of Applicant" in Part C--Sign and date.

If selecting family coverage, list all covered dependents.

Our health insurance subscribers MUST have both Part A and Part B of Medicare to remain eligible for our health plan. Therefore, to remain on our plan or obtain new coverage, any eligible Medicare member should not defer Part B of Medicare when he/she becomes eligible for it.

Any eligible Medicare member must provide proof of enrollment by submitting a photocopy of the applicable Medicare ID card.

Any eligible Medicare member must also complete the Medicare Blue Rx Prescription Drug Plan Group Enrollment Form. You can obtain this form by calling NDPERS at 328-3900 or 1-800-803-7377.

Part C Payment Method

If you are drawing a pension from a PERS defined benefit plan (NDPERS/NDHPRS), the Teacher's Fund for Retirement (TFFR), or the Job Service Retirement Plan, you can have your health insurance premium deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account.

If you are drawing a pension from TIAA-CREF or the NDPERS Defined Contribution Plan or you are an ex-legislator, your health insurance premiums must be withheld from a bank account.

You must sign and date this section for the form to be valid.

New Retiree

RETIREE LIFE INSURANCE APPLICATION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53622 (REV. 06/05)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • 400 East Broadway • Suite 505 • PO Box 1657 • Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3902

PART A MEMBER INFORMATION

Name (Last, First, Mi)		Social Security Number
☐ Single ☐ Widowed ☐ Married ☐ Divorced	Date if changing marital status	Date of Birth

PART B NDPERS GROUP LIFE INSURANCE

Effective Date:

☐ I elect **NOT** to Continue my Group Life Insurance

☐ I elect **To** continue my Group Life Insurance: (Check appropriate coverages below)

☐ Basic Life

☐ Supplemental Life: ☐ At Current Level of Coverage ☐ At a Reduced Level of Coverage: $_____.00

☐ Dependent Life: ☐ At Current Level of Coverage ☐ At a Reduced Level of Coverage: $_____.00

☐ Spouse Supplemental Life: ☐ At Current Level of Coverage ☐ At a Reduced Level of Coverage: $_____.00

☐ Beneficiary (ies) Update

PART C PAYMENT METHOD

RETIREMENT GROUP	PAYMENT OPTION (must select one)
☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE →	☐ Deduct from my Pension Check ☐ Withhold from bank account (MUST Complete SFN 50134)
☐ NDPERS DEFINED CONTRIBUTION ☐ TIAA-CREF ☐ EX - LEGISLATOR →	☐ Withhold from bank account (MUST Complete SFN 50134)

PART D DESIGNATION OF BENEFICIARY

Primary Beneficiary (ies) (If person enter: Last, First, Mi)	Relationship	Social Security No.	Birth Date	%Share must = 100%	Address
Contingent/Secondary Beneficiary(ies) (If person enter: Last, First, Mi)	**Relationship**	**Social Security No.**	**Birth Date**	**%Share must = 100%**	**Address**

PART E MEMBER AUTHORIZATION

I authorize all physicians and other medical professional, hospitals, and other medical care institution, insurers, medical or hospital service and prepaid health plans, employers and group policyholders, contract holders or benefit plan administrators to provide The Prudential Insurance Company of America and any benefit plan administrator, consumer reporting agencies, attorneys and independent claim administrators acting on Prudential's behalf with information concerning medical care, advice, treatment or supplies provide the patient including information on mental illness and any employment related information regarding the Patient. This information will be used for the purpose of evaluating and administering claims for benefits.

I read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any Benefit Plans insured based on this application.

_____ _____

Signature of Applicant Date Signed

PART F NDPERS USE ONLY

Group Number	Month the last life insurance premium will be paid:	Effective date of coverage:

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

Part A Member Information

Enter your name, social security number, date of birth, and marital status.

Part B NDPERS Group Life Insurance

Indicate the effective date of your election.

Check the appropriate box(es) to elect or not to elect and the levels of coverage you had as an active employee and wish to continue. You must continue the basic life to continue the employee supplemental, the employee supplemental to continue dependent life, and the dependent life to continue spouse supplemental.

Check the appropriate box(es) to either maintain the same level of coverage you had as an active employee or elect to decrease your level of coverage. NOTE: YOU CANNOT INCREASE ANY LEVELS OF COVERAGE AS A RETIREE.

Part C Payment Method

If you are drawing a pension from a PERS defined benefit plan (NDPERS/NDHPRS), the Teacher's Fund for Retirement (TFFR), or the Job Service Retirement Plan, you can have your life insurance premium deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account.

If you are drawing a pension from TIAA-CREF or the NDPERS Defined Contribution Plan or you are an ex-legislator, your life insurance premiums must be withheld from a bank account.

Part D Designation of Beneficiary

Use full legal name. (Example: "Anna May Smith," not Mrs. John Smith")

A member may designate contingent beneficiary (ies) who will receive benefits if the primary beneficiary (ies) predecease member.

If you have more that two designated beneficiaries in either the primary or contingent beneficiary sections, please submit a typed attachment and include your name, social security number, signature, and date.

NOTE:

Benefits are not paid out to minor children listed as beneficiaries unless a trust or guardianship has been established.

ESTATE DESIGNATION

If an estate is named, specify whose estate such as: "Estate of the Insured." Full name and address of the executor must be included.

TRUSTEE DESIGNATION

1. Trustee under the last will and testament of the insured, or his/her successors in trust, PROVIDED, HOWEVER, that if no claim is made by the Trustee within one year from the date of death of the insured or if the insured shall die leaving no last will and testament containing the trust covering this policy, the proceeds shall be payable to the estate of the insured. Payment of the proceeds of this policy to said Trustee or successors in trust shall fully and finally discharge the Company from all liability.

2. "The _____Trust Company, trustee under written trust agreement date (month, date, year) _____, or its successor or successors in trust, and payment of the proceeds of this policy to said Trustee or successor or successors shall fully and finally discharge the Company from all liability." Full name and address of trust administrator must be included.

IT IS IMPORTANT TO KEEP YOUR BENEFICIARY DESIGNATIONS CURRENT IF YOU EXPERIENCE LIFE CHANGE EVENTS.

Part E Member Authorization

You must sign and date this section for this form to be valid.

Part F NDPERS use only

PLEASE CONTACT NDPERS TO REQUEST THE PRUDENTIAL APPLICATION FOR CONVERSION OF GROUP LIFE INSURANCE.

Prudential Financial

Group Insurance

The Prudential Insurance Company of America
Disability Management Services

Waiver of Premium Unit
P.O. Box 482, Livingston, NJ 07039-0482

Tel 800-524-0542 Fax 973-548-7530

Group Life Claim for Total Disability Benefits—Employee Statement

Instructions to file a Claim for Group Life Insurance Coverage for Total Disability

1. Complete all sections of the **Employee Statement (Form GL.2003.015)**

2. Ask your doctor to complete the **Attending Physician's Statement GL.2002.119)**

3. Submit these completed forms according to the directions you received from your Benefits Office or mail them to:

The Prudential Insurance Company of America
Disability Management Services
Waiver of Premium Unit
P.O. Box 482
Livingston, NJ 07039-0482

Or fax the completed forms to:

973-548-7530

If you have any questions, please call our Group Life Claim Division at 800-524-0542 and a customer service representative will assist you.

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

CALIFORNIA RESIDENTS— For your protection, California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

NEW JERSEY RESIDENTS— Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK RESIDENTS— Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

PENNSYLVANIA RESIDENTS— Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

VIRGINIA RESIDENTS— Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit may have violated state law, is guilty of a crime, and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

Prudential Financial

Group Insurance

The Prudential Insurance Company of America
Disability Management Services
Waiver of Premium Unit
P.O. Box 482, Livingston, NJ 07039-0482
Tel 800-524-0542 Fax 973-548-7530

Group Life Claim For Total Disability Benefits—Employee Statement

Group Insurance Employee's Statement To be completed by Employee. Please complete all five sections.

1 Employer/ Association Information

Employer's Name

Control Number/s

Location/Division

Branch Number/s

2 Employee Information

First Name | MI | Last Name

Social Security Number

Date of Birth (MM DD YYYY)

Gender ☐ Male ☐ Female

Marital Status
☐ Unmarried ☐ Divorced
☐ Married ☐ Widowed

Spouse Date of Birth (MM DD YYYY)

Youngest Child Date of Birth (MM DD YYYY)

Street | Suite

City | State | ZIP Code

Your Mailing Address (if different from home address)

Street | Suite

City | State | ZIP Code

Primary Telephone Number

Work Telephone Number

Education—Highest Level Completed
☐ Elementary ☐ High School ☐ College ☐ Graduate School

List trade schools attended or special training received

Date of Employment (MM DD YYYY)

Date Last Worked (MM DD YYYY)

Date First Treated for This Condition (MM DD YYYY)

Date First Absent (MM DD YYYY)

Date Work Resumed (MM DD YYYY)

Date Expected to Return to Work (MM DD YYYY)

Prudential Financial

Employee's Social Security Number

2 Employee Information (Cont'd.)

Are you currently working at another occupation? ☐ Yes ☐ No

If yes, please provide occupation

Date of Hire (MM DD YYYY)

Are you currently seeking vocational assistance or retraining for another occupation? ☐ Yes ☐ No

Have you been approved for Social Security Disability Benefits or Canada/Quebec Pension Benefit because of disability? ☐ Yes ☐ No How many times have you applied?

Do you have Group Long Term Disability coverage with Prudential? ☐ Yes ☐ No

Have you converted your group coverage to an individual policy? ☐ Yes ☐ No

3 Job Information

Occupation

What Job Category best describes the claimant's functional abilities? (Please check the appropriate box)

☐ **Sedentary**	☐ **Light**	☐ **Medium**	☐ **Heavy**	☐ **Very Heavy**
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occassionally and/or Frequent Walk/Stand and/or Constant Push/Pull	Up to 25 lbs. frequently Up to 50 lbs. occassionally	25 to 50 lbs. frequently 50 to 100 lbs. occassionally	More than 50 lbs. frequently 100 lbs. occassionally

☐ **Other** (Please describe)

List your previous occupations

Job Title

Employer Name and Address

From (MM DD YYYY)

To (MM DD YYYY)

Job Title

Employer Name and Address

From (MM DD YYYY)

To (MM DD YYYY)

Prudential Financial

Employee's Social Security Number

4 Primary Care Physician

Name of Attending Physician (Please print)

First Name | MI | Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | ZIP Code

Specialty

5 Medical Information

Other Treating Physicians or Consultants

Name of Attending Physician (Please print)

First Name | Last Name

Specialty | Telephone Number

First Name | Last Name

Specialty | Telephone Number

List any hospital confinement for this disability

Name of Hospital and Address

Period Confined

From (MM DD YYYY)

To (MM DD YYYY)

Name of Hospital and Address

From (MM DD YYYY)

To (MM DD YYYY)

What medical condition is preventing you from working?

What impairment prevents you from performing the essential functions of your occupation or any other occupation?

If you are pregnant: Expected Delivery Date (MM DD YYYY) | Actual Delivery Date (MM DD YYYY)

Prudential Financial

Employee's Social Security Number

5 Medical Information (Cont'd.)

Name of Health Insurance Company

Telephone Number

What are your hobbies and/or other special interests?

I hereby certify that these statements are complete and true:

Employee's Signature X

Date (MM DD YYYY)

The following authorization must also be completed by the employee. When completed by the employee, this form should be returned to the Group Policyholder together with the Attending Physician's Statement of Disability (Form GL.2003.019) completed by the doctor currently treating the employee. Medical proof must be submitted covering the period from date last worked to present. If the employee is being treated by more than one physician for their current disability, it will be beneficial to have each doctor complete an Attending Physician's Statement.

Authorization for Release of Information to Prudential Insurance Company
This Authorization is intended to comply with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided treatment, payment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other health information concerning me to The Prudential Insurance Company of America (Prudential) and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I authorize my insurance company, employer, the Social Security Administration, or other person or institutions to provide any information, data, or records relating to my Social Security, workers' compensation, credit, financial, earnings, activities, or employment history to Prudential.

Unless limits* are shown below, this form pertains to all of the records listed above.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct My Providers to release and disclose my entire medical record without restriction.

This information is to be disclosed under this Authorization so that Prudential may: 1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential.

This authorization shall remain in force for 24 months following the date of my signature below, while the coverage is in force, except to the extent that state law imposes a shorter duration. A copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Prudential at: P.O. Box 482, Livingston, NJ 07039. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release the entire medical record, Prudential may not be able to process my claim for benefits and may not be able to make any benefit payments. I understand that I have a right to receive a copy of this authorization.

*Limits, if any:

Signature of Insured/ Patient or Personal Representative X

Date (MM DD YYYY)

Description of Personal Representative's Authority or Relationship to Patient

Notice to Montana residents: You or your authorized representative are entitled to receive a copy of this Authorization, and upon request, a record of any subsequent disclosures of personal or privileged information.

Prudential Financial

Group Insurance

The Prudential Insurance Company of America
Disability Management Services

Waiver of Premium Unit
P.O. Box 482, Livingston, NJ 07039-0482

Tel 800-524-0542 Fax 973-548-7530

Group Life Disability Benefit Attending Physician's Statement

1 To Be Completed By Employee

Employer's Name

Control Number

First Name

MI

Last Name

Social Security Number

Date of Birth (MM DD YYYY)

Gender ☐ Male ☐ Female

Street

Suite

City

State

ZIP Code

Occupation

I hereby authorize the release of information requested on this form by the below named physician for the purpose of claim processing.

Employee Signature X

Date (MM DD YYYY)

The employee is responsible for the completion of this form without expense to Prudential.

2 To Be Completed By Attending Physician

Clinical Diagnosis

Primary

Secondary

Secondary

ICD-9 Code

Pregnancy EDC (MM DD YYYY)

Pregnancy Actual Delivery Date (MM DD YYYY)

Relevant test procedures performed (Please provide results)

Date of Procedure (MM DD YYYY)

Surgical Procedure(s) Performed (Please be specific)

Current Medications

Prudential Financial

Employee's Social Security Number

2 Attending Physician Information (Cont'd.)

Was Claimant hospital confined? ☐ Yes ☐ No

If yes, please provide name and address of hospital

If hospitalized, give dates:

From (MM DD YYYY)

To (MM DD YYYY)

Other Treating Physicians or Consultants

Name of Attending Physician (Please print)

First Name

Last Name

Specialty

Telephone Number

First Name

Last Name

Specialty

Telephone Number

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Nature of Medical Impairment/Limitation (Please specify nature of corresponding loss of function)

Date when significant loss of function occurred: (MM DD YYYY)

Are there corresponding medical restrictions? (i.e., What actvities should the claimant not perform because of a significant risk to self or others?)

Target Date (MM DD YYYY)

Prognosis for Return to Function/Return to Work

Return to Work Plan (Please describe)

Prudential Financial

Employee's Social Security Number

2 Attending Physician Information (Cont'd.)

Describe medical obstacles to return to work

Are there any non-medical factors that have a significant impact on functional abilities (i.e., interpersonal, financial, family)?

Work-related illness or injury? ☐ Yes ☐ No

Was condition caused by a MVA? ☐ Yes ☐ No

If MVA, in what state did it occur?

First Visit: (MM DD YYYY)

Last Visit: (MM DD YYYY)

Frequency of Visits

What Job Category best describes the claimant's functional abilities? (Please check the appropriate box)

☐ **Sedentary**	☐ **Light**	☐ **Medium**	☐ **Heavy**	☐ **Very Heavy**
Negligible Weight Mostly Sitting	Up to 10 lbs. frequently Up to 20 lbs. occassionally and/or Frequent Walk/Stand and/or Constant Push/Pull	Up to 25 lbs. frequently Up to 50 lbs. occassionally	25 to 50 lbs. frequently 50 to 100 lbs. occassionally	More than 50 lbs. frequently 100 lbs. occassionally

☐ **Other** (Please describe)

3 Physician Information

First Name

MI

Last Name

Primary Telephone Number

Fax Number

Office Address

Suite

City

State

ZIP Code

Specialty

4 Fraud Notice

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Physician Signature X

Date (MM DD YYYY)

RETIREE CONTINUATION OF GROUP DENTAL COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53800 (REV. 01-06)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A MEMBER INFORMATION

Name (Last, First, MI)	Social Security Number

PART B NDPERS GROUP INSURANCE ONLY

Do you wish to continue your current coverage in the NDPERS Dental Plan? ☐ Yes ☐ No

If Yes, Current Level of Coverage: ☐ Self Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

☐ Reduced Level of Coverage (Self Only) (**SFN 53504 MUST accompany this form)**

Employees terminating employment, or otherwise losing eligibility, may continue their NDPERS Group Dental Coverage at their own expense for a maximum of 18 months subject to the following:

1. You must be a member of the plan at time of loss of eligibility.
2. Your spouse or any other dependent(s) applying for this continuation coverage must be a member of the plan at time of loss of eligibility.
3. You must complete and submit this election form to NDPERS within 60 days from your last date of coverage.

If you do not choose continuation coverage, your group dental coverage will end on the last day of the month for which premiums were paid.

PART C PAYMENT METHOD & MEMBER AUTHORIZATION

(If a payment method is not elected, you must submit your personal check for the monthly premium to NDPERS by the 1st day of each month. NDPERS will not send you monthly premium notices. Failure to remit your premium by the due date will result in loss of dental coverage.)

RETIREMENT GROUP	***PAYMENT OPTION – MUST SELECT ONE***
☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE →	☐ Deduct from pension check ☐ Withhold from bank account (Complete SFN 50134)
☐ TIAA-CREF ☐ NDPERS DEFINED CONTRIBUTION → ☐ EX-LEGISLATOR	☐ Withhold from bank account (Complete SFN 50134)

I have read this application in its entirety **(including the back page)** and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any benefit plans insured based on this application.

Signature of Member _____ Date Signed _____

PART D NDPERS USE ONLY

Group Number	Month the last dental insurance premium will be paid:	Effective date of coverage:

ORIGINAL TO NDPERS – PLEASE MAKE A PHOTOCOPY FOR YOUR

On July 1, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group plans offer employees and their families the opportunity for a temporary extension of coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end.

If you are the spouse of an employee covered by the employer’s group plan, you have the right to choose continuation coverage for yourself if you lose group coverage under the group plan for any of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse’s employment (for the reasons other than gross misconduct) or reduction in your spouse’s hours of employment with the employer.
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to (that is, covered by) Medicare.

In the case of a dependent child of an employee covered by the employer’s group plan, he or she has the right to continuation coverage if group dental coverage under the group plan is lost for any of the following reasons:

1. The death of the employee;
2. A termination of the employee’s employment (for reasons other then a gross misconduct) or reduction in the employee’s hours of employment wit the employer;
3. The employee’s divorce or legal separation;
4. The employee becomes entitled to (that is, covered by) Medicare;
5. The dependent child ceases to be a “dependent child” under the group plan.

Under the law, the employee or a family member has the responsibility to inform NDPERS of a divorce, legal separation or a child losing dependent status under the group plan within 60 days of the date of the event. The employer with whom you have your NDPERS group benefit plan has the responsibility to notify NDPERS of an employee’s death, termination, and reduction in hours of employment or Medicare entitlement.

Once is notified that one of these events has happened, you will in turn be notified that you have the right to choose continuation coverage. Under the law you have at least 60 days from the date you would lose coverage because of one of the events described above to inform NDPERS that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group insurance coverage will end. Not choosing continuation coverage may cause a break in your continued coverage and such break of more then sixty-three days may cause loss in coverage portability.

If you choose continuation of coverage, NDPERS is required to give you coverage, which, as of the time coverage is being provided is identical to the coverage provided under the group dental plan to similarly situated employees or family members.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18 months may extend to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security disability purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, you must notify NDPERS of the determination within 60-day s or before the end of the original 18-month period. The affected individual must also notify NDPERS within 30 days of any final determination that the individual is no longer disabled.

However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The employer no longer provides group coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become entitled to (that is, covered by) Medicare; or
5. You extend coverage for up to 29 months due to disability and there has been a final determination that you are no longer disabled.

New Retiree

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EMPLOYEE BENEFITS

RETIREE DENTAL INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53504 (REV. 03/04)

Policy Number: **GH-28275-8**

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A MEMBER INFORMATION

Name (Last, First, Mi)	Social Security Number		
Mailing Address	City	State	Zip Code + 4
Date of Birth	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Daytime Telephone Number

PART B ENROLLMENT/CHANGE

☐ Medicare Eligible ☐ Cancel Coverage ☐ Address Change ☐ Marriage ☐ Divorce ☐ Add Dependent ☐ Delete Dependent
☐ Loss of COBRA Coverage ☐ Loss of Other Employer Coverage ☐ Surviving Spouse – New Coverage ☐ Disability
☐ Retirement – Date of 1st Check ____/_____/_____ ☐ Surviving Spouse- Transferring from Contract # _____

PART C ELECT COVERAGE

☐ Retiree Only ☐ Retiree + Spouse ☐ Retiree + Child(ren) ☐ Retiree + Family

For Spouse and Dependent Coverage, Provide all information requested below:

Name (Last, First, Mi)	Relationship	Date of Birth	Sex	Marital Status*	Child Status**	Add	Drop

** For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, or Legally Separated.*
*** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.*

Other Dental Coverage Information (Complete if you and /or any dependent have Dental coverage with another insurer or carrier.)

Retiree/Dependent Name (Last, First, Mi)	Name and Address of Other Dental Insurer/Carrier	Policy/Plan Number	Effective Date	Other Dental Coverage Type
				☐Single ☐Family
				☐Single ☐Family

PART D PAYMENT METHOD

RETIREMENT GROUP	PAYMENT OPTION – MUST SELECT ONE
☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE →	☐ Deduct from pension check ☐ Withhold from bank account (Complete SFN 50134)
☐ TIAA-CREF ☐ NDPERS DEFINED CONTRIBUTION ☐ EX-LEGISLATOR →	☐ Withhold from bank account (Complete SFN 50134)

PART E WAIVE COVERAGE

IF YOU DO NOT WANT COVERAGE - COMPLETE THIS WAIVER SECTION.

I have been given the opportunity to apply for Group Dental Insurance offered by NDPERS and have decided not to accept the offer for:
(check all that apply) ☐ myself ☐ spouse only ☐ child(ren) only ☐ myself and entire family
because: ☐ I have other coverage through my spouse's employer ☐ I have other individual coverage ☐ Other _____
Should I desire to apply for dental insurance in the future, I realize that a "late entrant" penalty may be applied.

PART F MEMBER AUTHORIZATION

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime. I understand my coverage begins on the effective date assigned by ING.

I have read this application in its entirety **(including the back page)** and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any benefit plans insured based on this application.

_____ Member Signature

_____ Date of Signature

PART G NDPERS USE ONLY

Group Number	Effective date of coverage:	Effective date of change:

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

Please refer to the “Retiree Dental Coverage” sheet.

Part A Member Information

Enter your name, social security number, mailing address, date of birth, gender, marital status, and day time telephone number.

Part B Enrollment/Change

Check the appropriate “qualifying event”.

Part C Elect Coverage

Select the level of coverage. If electing Retiree + Spouse, Retiree + Child(ren), or Retiree + Family, complete spouse and dependent coverage information. If you are adding or dropping a spouse or dependent, ensure that you check the appropriate box.

Indicate if you and/or any dependent have other Dental coverage.

Part D Payment Method

If you are drawing a pension from a PERS defined benefit plan (NDPERS/NDHPRS), the Teacher’s Fund for Retirement (TFFR), or the Job Service Retirement Plan, you can have your dental insurance premium deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account.

If you are drawing a pension from TIAA-CREF or the NDPERS Defined Contribution Plan or you are an ex-legislator, your dental insurance premiums must be withheld from a bank account.

Part E Waiver of Coverage

If you do not wish to enroll in the dental plan, complete Parts A, E and F.

Part F Member Authorization

You must sign and date this section for the form to be valid.

Part G NDPERS Use Only

RETIREE CONTINUATION OF GROUP VISION INSURANCE COVERAGE (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53801 (REV.01-06)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A MEMBER INFORMATION

Name (Last, First, MI)	Social Security Number

PART B NDPERS GROUP INSURANCE ONLY

Do you wish to continue your current coverage in the NDPERS Group Vision Insurance Plan? ☐ Yes ☐ No

If Yes Current Level of Coverage: ☐ Self Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

☐ Reduced Level of Coverage (Self Only)

Employees terminating employment, or otherwise losing eligibility, may continue their NDPERS Group Vision Coverage at their own expense for a maximum of 18 months subject to the following:

1) You must be a member of the plan at time of loss of eligibility.
2) Your spouse or any other dependent(s) applying for this continuation coverage must be a member of the plan at time of loss of eligibility.
3) You must complete and submit this election form to NDPERS within 60 days from your last date of coverage.

If you do not choose continuation coverage, your group vision coverage will end on the last day of the month for which premiums were paid.

PART C PAYMENT METHOD & MEMBER AUTHORIZATION

(If a payment method is not elected, you must submit your personal check for the monthly premium to NDPERS by the 1st day of each month. NDPERS will not send you monthly premium notices. Failure to remit your premium by the due date will result in loss of vision coverage.)

RETIREMENT GROUP	***PAYMENT OPTION – MUST SELECT ONE***
☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE →	☐ Deduct from pension check ☐ Withhold from bank account (Complete SFN 50134)
☐ TIAA-CREF ☐ NDPERS DEFINED CONTRIBUTION ☐ EX-LEGISLATOR →	☐ Withhold from bank account (Complete SFN 50134)

I have read this application in its entirety **(including the back page)** and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any benefit plans insured based on this application.

_____ _____

Signature of Member Date Signed

PART D NDPERS USE ONLY

Group Number	Month the last vision insurance premium will be paid:	Effective date of coverage:

ORIGINAL TO NDPERS – PLEASE MAKE A PHOTOCOPY FOR YOUR

RETIREE CONTINUATION OF GROUP VISION INSURANCE COVERAGE (COBRA)

On July 1, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group plans offer employees and their families the opportunity for a temporary extension of coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end.

If you are the spouse of an employee covered by the employer’s group plan, you have the right to choose continuation coverage for yourself if you lose group coverage under the group plan for any of the following four reasons:

1. The death of your spouse;
2. A termination of your spouse’s employment (for the reasons other than gross misconduct) or reduction in your spouse’s hours of employment with the employer.
3. Divorce or legal separation from your spouse; or
4. Your spouse becomes entitled to (that is, covered by) Medicare.

In the case of a dependent child of an employee covered by the employer’s group plan, he or she has the right to continuation coverage if group vision coverage under the group plan is lost for any of the following reasons:

1. The death of the employee;
2. A termination of the employee’s employment (for reasons other then a gross misconduct) or reduction in the employee’s hours of employment wit the employer;
3. The employee’s divorce or legal separation;
4. The employee becomes entitled to (that is, covered by) Medicare;
5. The dependent child ceases to be a “dependent child” under the group plan.

Under the law, the employee or a family member has the responsibility to inform NDPERS of a divorce, legal separation or a child losing dependent status under the group plan within 60 days of the date of the event. The employer with whom you have your NDPERS group benefit plan has the responsibility to notify NDPERS of an employee’s death, termination, and reduction in hours of employment or Medicare entitlement.

Once is notified that one of these events has happened, you will in turn be notified that you have the right to choose continuation coverage. Under the law you have at least 60 days from the date you would lose coverage because of one of the events described above to inform NDPERS that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group insurance coverage will end. Not choosing continuation coverage may cause a break in your continued coverage and such break of more then sixty-three days may cause loss in coverage portability.

If you choose continuation of coverage, NDPERS is required to give you coverage, which, as of the time coverage is being provided is identical to the coverage provided under the group vision plan to similarly situated employees or family members.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. The 18 months may extend to 29 months if an individual is determined by the Social Security Administration to be disabled (for Social Security disability purposes) as of the termination or reduction in hours of employment or within 60 days thereafter. To benefit from this extension, you must notify NDPERS of the determination within 60-day s or before the end of the original 18-month period. The affected individual must also notify NDPERS within 30 days of any final determination that the individual is no longer disabled.

However, the law also provides that continuation coverage may be cut short for any of the following five reasons:

1. The employer no longer provides group coverage to any of its employees;
2. The premium for your continuation coverage is not paid on time;
3. You become entitled to (that is, covered by) Medicare; or
5. You extend coverage for up to 29 months due to disability and there has been a final determination that you are no longer disabled.

New Retiree

RETIREE VISION INSURANCE ENROLLMENT/CHANGE

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM

SFN 53505 (REV. 03/04)

AMERITAS LIFE INSURANCE CORP.

Policy Number: **G010-350308**

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A MEMBER INFORMATION

Name (Last, First, Mi)		Social Security Number	
Mailing Address		City	State	Zip Code + 4
Date of Birth	Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married	Daytime Telephone Number

PART B ENROLLMENT/CHANGE

☐ Medicare Eligible ☐ Cancel Coverage ☐ Address Change ☐ Marriage ☐ Divorce ☐ Add Dependent ☐ Delete Dependent
☐ Loss of COBRA Coverage ☐ Loss of Other Employer Coverage ☐ Surviving Spouse – New Coverage ☐ Disability
☐ Retirement – Date of 1st Check ____/_____/_____ ☐ Surviving Spouse- Transferring from Contract # _____

PART C ELECT COVERAGE

☐ Retiree Only ☐ Retiree + Spouse ☐ Retiree + Child(ren) ☐ Retiree + Family

For Spouse and Dependent Coverage, Provide all information requested below:

Name (Last, First, Mi)	Relationship	Date of Birth	Sex	Marital Status*	Child Status**	Add	Drop

** For Marital Status, enter one of the following: Single, Married, Divorced, Widowed, or Legally Separated.*
*** For Child Status, indicate "S" if full-time student or "H" if handicapped, or leave blank if neither.*

Other Vision Coverage Information (Complete if you and /or any dependent have Vision coverage with another insurer or carrier.)

Retiree/Dependent Name (Last, First, Mi)	Name and Address of Other Vision Insurer/Carrier	Policy/Plan Number	Effective Date	Other Vision Coverage Type
				☐Single ☐Family
				☐Single ☐Family

PART D PAYMENT METHOD

RETIREMENT GROUP

☐ NDPERS/NDHPRS ☐ TFFR ☐ JOB SERVICE → **PAYMENT OPTION – MUST SELECT ONE**
☐ Deduct from pension check
☐ Withhold from bank account (Complete SFN 50134)

☐ TIAA-CREF ☐ NDPERS DEFINED CONTRIBUTION ☐ EX-LEGISLATOR → ☐ Withhold from bank account (Complete SFN 50134)

PART E WAIVE COVERAGE

IF YOU DO NOT WANT COVERAGE - COMPLETE THIS WAIVER SECTION.

I have been given the opportunity to apply for Group Vision Insurance offered by NDPERS and have decided not to accept the offer for:
(check all that apply) ☐ myself ☐ spouse only ☐ child(ren) only ☐ myself and entire family
because: ☐ I have other coverage through my spouse's employer ☐ I have other individual coverage ☐ Other _____
Should I desire to apply for vision insurance in the future, I realize that a "late entrant" penalty may be applied.

PART F MEMBER AUTHORIZATION

To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime. I understand my coverage begins on the effective date assigned by Ameritas.

I have read this application in its entirety **(including the back page)** and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any benefit plans insured based on this application.

_____ Member Signature

_____ Date of Signature

PART G NDPERS USE ONLY

Group Number	Effective date of coverage:	Effective date of change:

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

Please refer to the “Retiree Vision Coverage” sheet.

Part A Member Information

Enter your name, social security number, mailing address, date of birth, gender, marital status, and day time telephone number.

Part B Enrollment/Change

Check the appropriate “qualifying event”.

Part C Elect Coverage

Select the level of coverage. If electing Retiree + Spouse, Retiree + Child(ren), or Retiree + Family, complete spouse and dependent coverage information. If you are adding or dropping a spouse or dependent, ensure that you check the appropriate box.

Indicate if you and/or any dependent have other Vision coverage.

Part D Payment Method

If you are drawing a pension from a PERS defined benefit plan (NDPERS/NDHPRS), the Teacher’s Fund for Retirement (TFFR), or the Job Service Retirement Plan, you can have your vision insurance premium deducted from your pension check. If your pension check is not large enough, you can have the premium withheld from a banking account.

If you are drawing a pension from TIAA-CREF or the NDPERS Defined Contribution Plan or you are an ex-legislator, your vision insurance premiums must be withheld from a bank account.

Part E Waiver of Coverage

If you do not wish to enroll in the vision plan, complete Parts A, E and F.

Part F Member Authorization

You must sign and date this section for the form to be valid.

Part G NDPERS Use Only

New Retiree

AUTHORIZATION FOR AUTOMATIC PREMIUM DEDUCTION

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 50134 (Rev. 09/05)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS• 400 East Broadway, Suite 505• PO Box 1657• Bismarck • ND • 58502-1657
(701) 328-3900 or (800) 803-7377 • Fax: (701) 328-3920

PART A CONTRACT HOLDER INFORMATION (Must Be Completed By Member)

Contract Holder (Last, First, Mi)	Social Security Number

I authorize the North Dakota Public Employees Retirement System (NDPERS) and the financial institution named on this form to initiate electronic fund transfer (EFT) from my designated account and for the monthly insurance premiums indicated below. I consent to the financial institution sharing my customer information with NDPERS for the purpose of completing the EFT arrangement.

☐ Checking Account ☐ Savings Account | ☐ Health ☐ Life ☐ Dental ☐ Vision

This authorization will remain in effect until I notify you in writing to cancel it in such time as to afford NDPERS a reasonable opportunity to act on it. The premium amount will be deducted from your account by the fifth working day of each month. Your financial institution may charge an additional fee for this service.

I agree to the terms listed on this authorization.

_____ _____
Signature of Contract Holder as it Appears Above Date

PART B FINANCIAL INSTITUTION (Must Be Completed By Institution)

Name of Financial Institution

Mailing Address	City	State	Zip Code

Payee's Account Number	Type of Account
	☐ Checking ☐ Savings

Routing Number (9 Digits) ☐☐☐☐☐☐☐☐☐

_____ _____
Signature of Financial Institution Representative Date of Signature

Financial Institution Representative (Please Print)	Title	Telephone Number

PART C NDPERS USE ONLY

Group Number	Effective Date:

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR

INSTRUCTIONS AND CONDITIONS

If you wish to have your monthly insurance premiums deducted from your savings or checking account, you must complete this form to authorize this action and attach a void check for the account from which you want your premium deducted. The North Dakota Public Employees Retirement System will deduct these premiums to the point you authorize. The financial institution may be any bank, savings bank, savings and loan association or similar institution, or Federal or State chartered credit union.

THIS FORM ONLY AUTHORIZES DEDUCTIONS FROM YOUR ACCOUNT

PART A CONTRACT HOLDER INFORMATION

Print or type the full name and social security number of the Contract Holder. Indicate the type of account from which the premium is to be deducted and the plan(s) the deduction applies to. Sign and date the form.

PART B FINANCIAL INSTITUTION SECTION

After completing the top portion of this form, the form should be delivered or sent to the designated financial institution. Upon completion, you and the financial institution should retain a photocopy for your records and the original is to be sent to:

North Dakota Public Employees Retirement System
P.O. Box 1657
Bismarck, ND 58502-1657
Telephone: (701) 328-3900

If you have any questions please call the NDPERS office at: (701) 328-3900 or (800) 803-7377

CANCELLATION INSTRUCTIONS

When entered in your record with the North Dakota Public Employees Retirement System, this authorization will remain in effect until canceled by written notice by you to the North Dakota Public Employees Retirement System, or in the event of your death. The financial organization should also be notified if you cancel this agreement.

The financial organization may cancel their agreement by providing you a written notice 30 days in advance of the cancellation date. You must advise the North Dakota Public Employees Retirement System if this authorization is canceled. The financial organization cannot cancel this authorization by advice to the North Dakota Public Employees Retirement System.

The form is due back in our office by the 15th of the month prior to the month you want to begin your premium deduction.

UNUM Life Insurance Company of America
Portland, Maine 04122

Election for Portable Coverage – B
Long Term Care

Mail to: Unum LTC Customer Services
2211 Congress Street
Portland, Maine 04122-1760

Portability Number: 224998

To be completed by the employer

Company Data: *Company name* | *Plan number*

Company Address: *Street* | *City* | *State/Zip*

Employee Name: *Last name* | *First name* | *Middle initial*

Employee Data: *Date of birth* | *Social Security number* | ☐ *Male* ☐ *Female*

Person terminating group coverage: *Name(s)* | ☐ *Employee* ☐ *Family Member*

Reason person is terminating group coverage: ☐ *Termination of Employment* ☐ *Death of spouse* ☐ *Divorce* ☐ *Other* _____

Date group coverage terminates: *Month* *Day* *Year*

Current monthly premium payment: *Employee* $ /month | *Spouse* $ /month

Signature of Employer: **Date:**

To be completed by the Employee

If you are an insured employee, you may be eligible to port your Long Term Care Insurance after your group coverage terminates. If you wish to elect portable coverage, complete this section and send this form to UNUM within 31 days after your group coverage terminates. You must include your first premium payment, which is based on the payment option you select below. **You will be responsible for the entire cost of your coverage.**

Mailing Address: *Street* | *City* | *State/Zip*

Payment options: *Quarterly* ☐(3x monthly rate) | *Semi-annually* ☐(6x monthly rate) | *Annually* ☐(12x monthly rate)

Signature of Employee: **Date:**

To be completed by the Employee's Family Member

If you are the insured family member or former family member of the above employee, you may be eligible to port of your Long Term Care Insurance after your group coverage terminates. If you wish to elect portable coverage, please complete this section and send this form to UNUM within 31 days after your group coverage terminates. You must include your first premium payment, which is based on the payment option you select below. **You will be responsible for the entire cost of your coverage.**

Name: *Last name* | *First name* | *Middle Initial*

Mailing Address: *Street* | *City* | *State/Zip*

Data: *Date of birth* | *Social Security number* | ☐ *Male* ☐ *Female*

Payment Options: *Quarterly* ☐(3x monthly rate) | *Semi-annually* ☐(6x monthly rate) | *Annually* ☐(12x monthly rate)

Signature of Employee's Family Member: **Date:**

Information About Portable Coverage

Should The Certificate of Insurance be Kept?

If portable coverage is elected, you will not receive a new Portable Certificate of Insurance. The coverage you or your family member had under the group plan continues under ported coverage.

Can Coverage Be Changed?

You or your family member may apply at any time to increase coverage by filling out a new application, which includes evidence of insurability. Call Unum at (800) 227-4165 for assistance.

When Are Premiums Due And What Is The Grace Period?

Premium payment options include quarterly, semi-annually, or annually. Mail the first premium payment with this form. Unum will mail subsequent bills to you or your family member at the address(es) provided. A grace period of 45 days after the premium due date will be allowed for the payment of each premium.

Where Should Premium Payments Be Sent?

You or your family member must pay the premium directly to Unum for portable coverage to be continued. The address is:

Unum LTC Customer Services
2211 Congress Street
Portland, Maine 04122-1760

How Long Will Unum Continue To Pay For Long Term Care Benefits?

Unum will continue monthly payments for long term care benefits until the earliest of the following dates:

--The date the person is no longer disabled,

--The date the person dies, or

--The date the person's total benefit payments equal the lifetime maximum amount.

When Will This Portability Coverage Terminate?

A person's portable coverage will terminate on the earlier of:

- The end of the period for which the required premiums for the ported coverage were last paid to Unum, or
- The date the person dies.

CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM
SFN 53512 (01-05)

In compliance with the Federal Privacy Act of 1974, the disclosure of the individual's social security number on this form is mandatory pursuant to 26 U.S.C. Sec. 3402. The individual's social security number will be used for tax reporting and as an identification number.

NDPERS • PO Box 1657 • Bismarck, • North Dakota 58502-1657
(701) 328- 3900 • 1-800-803-7377 • Fax 701-328-3920

PART A PARTICIPANT/QUALIFIED BENEFICIARY INFORMATION

Name (Last, First, Mi)		Member Id Number **(Required)**	
Daytime Telephone Number		Social Security Number **(Required)**	
Address	City	State	Zip Code + 4

PART B CONTINUATION OF COVERAGE ELECTION / WAIVER

Do you wish to continue your current participation in the NDPERS Medical Spending Account?

☐ Yes ☐ No

If you elect Medical Spending Continuation coverage, it will be in effect to the end of the current plan year, or December 31.

PART C AUTHORIZATION OF APPLICANT

I have read the information in its entirety, **including the back page**, and agree to abide by the terms of the Plan Document. I certify, under penalties of perjury, that the information submitted on this form is true, correct and complete.

_____ _____

Applicant Signature Date of Signature

ORIGINAL TO NDPERS – PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS

CONTINUATION OF COVERAGE IN A MEDICAL SPENDING ACCOUNT (COBRA)
SFN 53512 (01-05)

Entitlement to COBRA Coverage
Under provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, you have the opportunity to extend your participation in the NDPERS Medical Spending Account to the end of the current plan year.

Participants may elect to continue coverage in the Medical Spending Account if they terminate employment for reasons other than gross misconduct or become ineligible due to a reduction in hours of employment.

Qualified Beneficiaries Your spouse or dependent(s) may elect to continue coverage in a medical spending account under the following circumstances:

1. Participant's Death
2. Divorce or legal separation
3. A dependent child ceases to be a "dependent child" under the group health plan.

Under the law, it is the responsibility of the person seeking continuation coverage to inform NDPERS of a divorce, legal separation or a child losing dependent status within 60 days of the date of the event.

The employer has the responsibility to notify NDPERS of a participant's death, termination, or reduction in hours of employment.

You will have 60 days from the date of this notice to inform NDPERS that you want continuation coverage.

Length of COBRA Coverage

You, your spouse or dependent(s), are eligible to receive continuation coverage until the end of the plan year, or December 31, in which the qualifying event occurred.

COBRA Coverage Premiums

To continue your coverage, submit the premium amount plus a two percent (2%) administrative fee by the first of each month.

If you fail to pay the premium on time, your coverage will terminate on the last day of the month for which a contribution was received.

Continuation coverage under COBRA is provided subject to your eligibility. NDPERS reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible for coverage.

IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS OF THE DATE OF THIS NOTICE YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE